The Journal

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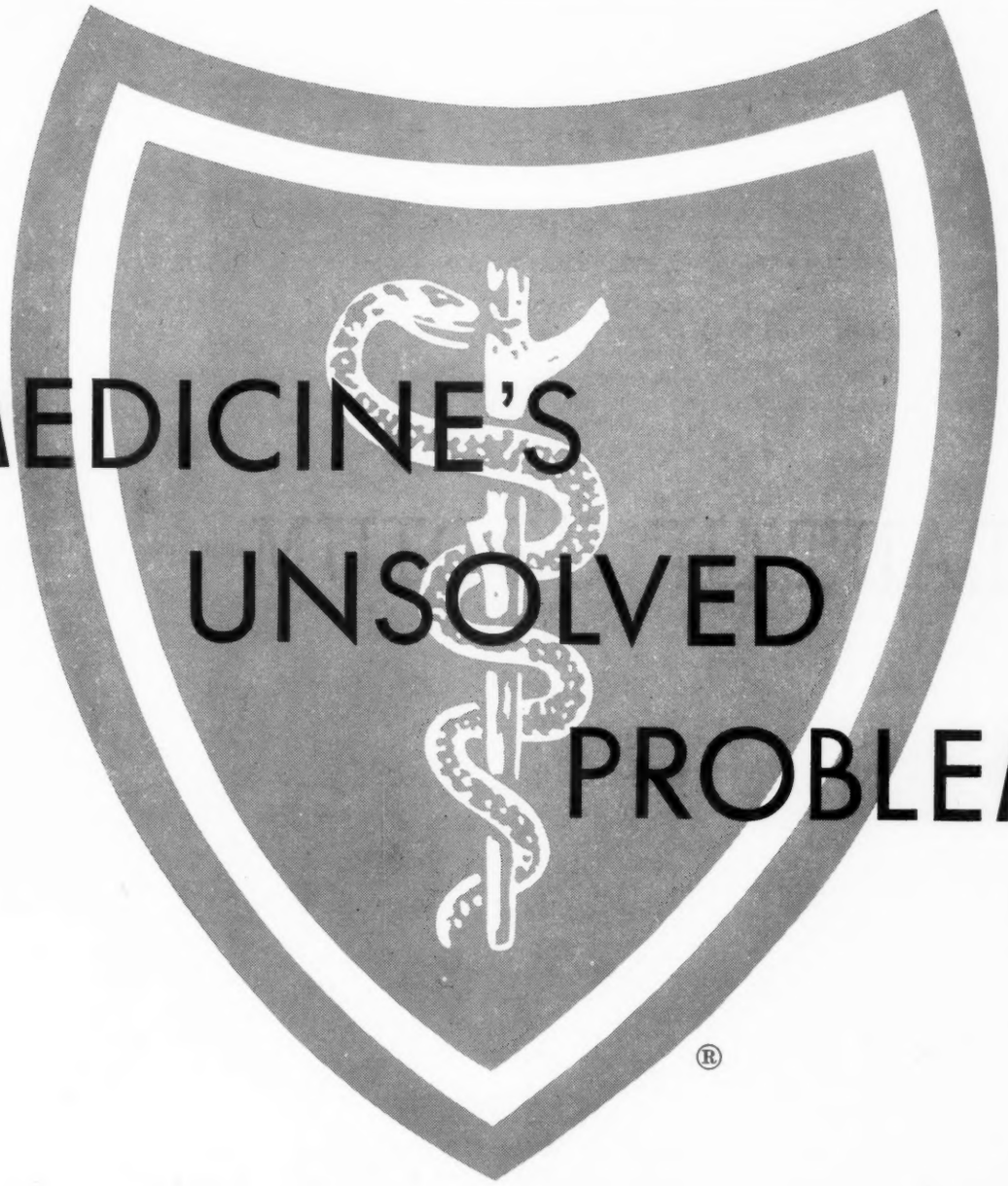

MEDICINE'S UNSOLVED PROBLEM

Robert L. Novy, M. D., discusses one of the most serious challenges confronting the Medical Profession

(Turn to Page 707)

normal living for....

at work and at play

adults should be encouraged
to work...and every
effort should be made
to keep children in school.
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and proper treatment,
the majority of epileptics,
like the diabetics, can carry
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THE JOURNAL
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VOLUME 54 JUNE, 1955 NUMBER 6

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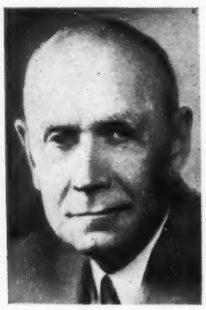

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John F. Sander, M.D.

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Civic Auditorium—Pantlind Hotel, Grand Rapids
Wednesday-Thursday-Friday, September 28, 29, 30, 1955
YOU are invited to attend the Ninetieth

ALCOHOLISM CONFERENCE—JULY 27-29

MSMS is among the twenty-three co-sponsoring agencies planning a statewide conference on the topic "Alcoholism in Our Society" which will be held at Western Michigan College of Education, Kalamazoo, beginning at 4 p.m., Wednesday, July 27, and ending at noon, July 29.

Several agencies are co-operating with the Michigan State Board of Alcoholism in staging the conference, which will deal with alcoholism as it relates to health, law, social welfare, and education.

The meeting Thursday afternoon, July 28, will be devoted to alcoholism and health with three doctors of medicine featured as speakers: R. M. Athay, M.D., Detroit, "Clinical Approach"; C. M. Schrier, M.D., Kalamazoo, "Psychiatric Aspects of Alcoholism"; and C. K. Stroup, M.D., Flint, "Hospitalization of Alcoholism."

Three other M.D.'s appointed by MSMS will serve as moderators to panel discussions following the presentations by these speakers: C. M. Schrier, M.D.; R. A. Morter, M.D., and D. G. May, M.D., all of Kalamazoo.

The Conference will concern itself also with how the professions, legal, teaching, ministry, social welfare, and industry, can jointly co-operate in dealing with alcoholism as a major public health problem.

It is requested that a check in the amount of $15.00 accompany reservation requests to be sent to the Division of Field Services Western Michigan College, Kalamazoo, Michigan, before July 18. Reservation includes meals, room, linen and maid service in one of the modern dormitories at the College. Free parking in the dormitory lot is available. Refund requests for necessary cancellations due to change in plans should be received by July 22.

MENTAL HEALTH IN PERIODIC HEALTH APPRAISAL

The following statement of responsibility of the doctor of medicine to the patient in mental ill health was adopted recently by the Committee on Mental Health of the Michigan State Medical Society:

"It is an inescapable fact that Mental Health is the Number One health problem in America. Conservative estimates indicate that one out of every twelve persons will be afflicted by some form of mental or emotional disorder. Latest reports reveal that 700,000 mental patients now occupy more than 50 per cent of all the hospital beds in the United States and that 30 per cent of all patients who enter general hospitals suffer from illnesses that are fundamentally emotional in character. In addition, it is well known that at least one-half of the patients who consult their family physicians do so because of symptoms which have an emotional origin. Finally, the sum of $1,100,000,000 is paid out each year for the care of mentally ill patients, an amount which represents one-third of the entire national budget for medical care.

"The foregoing facts impose a responsibility on every physician to enlarge his therapeutic armamentarium to the point where he can be of service to the patient in mental ill health. The foregoing facts impose no less an obligation on the Medical Society to encourage its members to assume this responsibility. It is obvious, therefore, that any periodic health appraisal must include an awareness of the emotional status of the persons examined."

This statement was approved by the Executive Committee of The Council, Michigan State Medical Society, at its meeting of April 20.

HIGHLIGHTS OF THE EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of April 20, 1955

Ninety-three items were presented to the Executive Committee of The Council at its April 20 meeting in Kalamazoo. Chief in importance were:

- **Salk Polio Vaccine.**—Background of events emerging statewide and in the Legislature since the April 12 evaluation report on Salk polio vaccine was presented by Secretary Foster, including April 9 letter to MSMS membership. Background for a statement re a uniform fee that could be recommended for use throughout the state was thoroughly discussed and motion was made "that the Executive Committee of The Council recommend a minimum of $2.00 per injection for office administration of Salk polio vaccine, plus the cost of the vaccine—as a fee only during this public health emergency." A night letter to the 55 component county medical societies with explanatory information on this action was authorized, together with a news release to the public.

  Jonas E. Salk, M.D., and Michigan's own

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HIGHLIGHTS OF THE COUNCIL

(Continued from Page 642)

Thomas Francis, Jr., M.D., were complimented by the Executive Committee of The Council for the development and the evaluation of the Salk polio vaccine; the Michigan delegation to the AMA House of Delegates was authorized to develop a suitable resolution complimenting Doctors Salk and Francis, for presentation to the AMA House of Delegates at June Atlantic City session.

A vote of thanks was extended to R. R. Dew, M.D., of Kalamazoo, for his presence and excellent information on the subject of Salk polio vaccine distribution.

- **Beaumont Memorial.**—Senate Concurrent Resolution No. 34 (adopted by the 1955 Michigan Legislature) re gift of the Beaumont Memorial to the State of Michigan, was read and ordered published in JMSMS and framed for hanging in the Beaumont Memorial and in the MSMS headquarters at Lansing. A vote of thanks to the Michigan Legislature was spread upon the minutes of the Executive Committee.
- **Committee Reports.**—The following committee reports were presented and given consideration: (a) Geriatrics Committee, meeting of March 15; (b) Mental Health Committee, March 16; (c) Tuberculosis Control Committee, March 18; (d) Child Welfare Committee, March 31 (including four subcommittee reports); (e) Legislative Committee, March 30; (f) Advisory Committee to Michigan United Fund, Inc., March 30; (g) National Defense Committee, April 6; (h) Rheumatic Fever Control Committee, April 13; (i) Rural Medical Service Committee, April 14; (j) Maternal Health Committee, April 14 (including four subcommittee reports; (k) Special Committee with Veterans Organizations, April 19; (1) M.D. Placement Program, April 20; (m) Basic Science Study Committee, April 12.
- **Report from E. F. Sladek, M.D.,** Traverse City, on migratory labor situation in Michigan was accepted, with thanks.
- **Joint meeting** of this Executive Committee with the Executive Committee of the Board of Commissioners of the State Bar of Michigan was set for October 19, and with the Executive Committee of the Board of Michigan Hospital Service for December 14.
- **President Robert H. Baker, M.D.,** Pontiac, announced that Dr. Charles L. Anspach, Ph.D., President of Central Michigan College, Mt. Pleasant, had been selected as 1955 Biddle Lecturer.
- **R. D. Mudd, M.D.,** Saginaw, and T. I. Boileau, M.D., Birmingham, were appointed to the Industrial Health Committee; C. H. Adams, M.D., Flint, was appointed to the Geriatrics Committee.
- **1955 Annual Session.**—Grand Rapids: (a) Felix Alfenito, M.D., Grand Rapids, was appointed General Chairman of Arrangements for the 1955 MSMS Annual Session in Grand Rapids. (b) **R. A. Johnson, M.D.,** Detroit, H. A. Towsley, M.D., Ann Arbor, and John M. Wellman, M.D., Lansing, were selected as Discussion Conference Leaders.

  (c) **Urological Section** request for a noonday section meeting, Wednesday, September 28, to avoid conflict with American Urological Society meeting in Chicago that evening, was approved.
- **Report of Goldie B. Corneliuson, M.D.,** Lansing, on Conference of Maternal and Child Care, held in Chicago March 19, was received with thanks; report of B. L. Masters, M.D., on National Rural Health Conference in Mil-

(Continued on Page 716)

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physician groups in Michigan, follows:

1955		
June 27-30	Eighth Annual Conference on Aging	Ann Arbor
August	Fifth Annual Clinic, Central Michigan Committee, ACS Michigan Committee on Trauma, plus Michigan National Guard Medical Personnel, and Medical Society of North Central Counties	Grayling
August 25-26	Coller-Penberthy Clinic	Traverse City
September 26-27	Annual Session of the House of Delegates (MSMS)	Grand Rapids
September 28-30	MSMS Annual Session	Grand Rapids
October	Clara Elizabeth Fund for Maternal Health and Genesee County Medical Society	Flint
October 14	Michigan Cancer Conference	East Lansing
October 17-19	Eighth Annual Scientific Meeting—Detroit Institute of Cancer Research.	Detroit
Autumn	MSMS Postgraduate Extramural Courses	State-wide
November 1-3	International Symposium: Units of Biological Structure and Function. Henry Ford Hospital.	Detroit
November 9-10	Mich. Academy of General Practice Ninth Annual Fall Post-Graduate Clinic.	Detroit
April 11, 1956	Tenth Annual Cancer Day	Flint

PR REPORT

POLIO VACCINE CONFUSION AND FACT

KEEPING ABREAST OF THE SITUATION in itself was a difficult problem in medical-public relations, once the announcement was made that the Salk polio vaccine had been proven effective and potent. Keeping *ahead* of the situation became a major project; and those who govern PR policy for MSMS were convinced early in the proceedings—even before the 1954 field trials—that only by anticipatory measures could the situation adequately be met.

As this is written there are still many questions to be resolved, but it's not too early for a preliminary, factual review. The final result, PR-wise, must be written sometime months from today. To date, however, some of the near-hysteria has subsided to some degree and a strong movement to write into Michigan law the professional fee for administering the vaccine has abated. But confusion still exists!

INTENSE PUBLIC INTEREST in the evaluation report for the 1954 field experiment rose to a peak during the days immediately preceding release of the report. Advance "leaks" and the carefully-planned and publicized announcement event primed the public for a favorable report on April 12. Sensing the "immediate and compelling demand" for the limited commercial supply which would follow any favorable report, MSMS leaders directed a letter on April 9 to all members strongly emphasizing to Michigan M.D.'s that "the public welfare would best be served" by inauguration of a voluntary system of control reserving the available vaccine for three specified priority groups most susceptible to polio.

It was further pointed out that (1) there must be public education effort, with the co-operation of M.D.'s, to explain the need for these temporary voluntary controls, and (2) local plans for inoculating persons in priority groups who were unable to pay for the vaccine must be given primary consideration.

All Michigan newspapers and radio and television stations were presented with the MSMS recommendations in a follow-up news release on April 11.

GOVERNMENT CONTROLS appeared to be the obvious alternative if a voluntary system was not established at the outset.

When blazing headlines on April 12 declared the vaccine to be "safe, potent, and effective," the wisdom of this advance preparation by MSMS was proven. Public demand in a few days grew even beyond the proportions foreseen. Rumors and considerable misinformation raced through the halls of the Michigan State Capitol, in particular.

The availability of vaccine to indigents was a persistent question. To meet this, MSMS issued a statement on April 19 re-emphasizing the long-standing policy of no professional fee for immunization of indigents certified by the County Department of Social Welfare. It was pointed out that state purchase of the vaccine for indigents was already possible under the Social Welfare Act. As in other programs, inoculations would be administered in the office of the M.D. of the patient's choice, with the same priority system used for non-indigents.

The statement on indigents was made only after conferences with legislative leaders, State Health Department representatives, and the State Social Welfare Department.

THE LEGISLATIVE PROPOSAL to appropriate funds for state purchase of Salk vaccine for all school-age children, prompted by a message from Lt. Governor Philip A. Hart, in view of Governor Williams' absence from Michigan and a bi-partisan groundswell of sentiment favoring the plan, stirred up several objectionable side issues. Most important of these was a strong indication that one element in the Legislature was determined to set an objectionable precedent by writing into the bill itself the professional fee of the M.D. administering the vaccine.

Before this new threat could gain a secure foothold, the Executive Committee of The Council made an unprecedented recommendation to all county medical societies that a special fee of $2 per injection be adopted during the temporary public health emergency while the new vaccine was in short supply. This fee was not to include the cost of the vaccine and was, in fact, well in line with the voluntary schedule already worked out by many county societies.

THIS PROMPT ACTION confirmed the faith the majority of legislators have in the Michigan medical profession. In a brief floor flurry in the House of Representatives, a series of fee-setting amendments to the vaccine appropriation bill failed to pass and the cynics were defeated.

ANOTHER INTERESTING SIDELIGHT to the polio vaccine situation is yet to be fully developed at the time this report is written, but

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Tenth Annual National Rural Health Conference

Following is a summary of the tenth annual National Rural Health Conference to which Drs. Spaulding, Fyvie and Brooker L. Masters were delegates. It seemed to me that this tenth conference was even more beneficial than the previous ninth one held in Dallas in 1954. It appears that some of the issues which keep cropping up at each conference are becoming more clear and also the possibilities of solutions are more apparent to those who attend. Of course, as in all conferences of this nature, the only true results are those which the conferees take back and put into practice in their home communities. It seems that the topics discussed are becoming increasingly more apparent in the home communities. Therefore, it is my opinion that this National Conference has definitely produced results in its ten years of activity and probably warrants continued support for the indefinite future.

The Conference opened on Thursday morning, February 24, with a meeting of all the doctors present. It was interesting that the general theme of this Thursday morning's session was the obtaining of more general practitioners, both in the city and in the rural areas. It was also the conclusion of this particular part of the meeting that the major ways of increasing the supply of general practitioners involved the following methods: Preceptorship, Senior Day Activities, Selection of Proper Men to be Doctors (not such concentration on scholastic averages), and Selection of students from the small communities to enter medical school training. These subjects are very common matters of thought for the Michigan Committee on Rural Medical Service.

The meeting on Farm and Home Safety was very conclusive in its opinion that many accidents —in fact, most accidents—are the result of emotional instability. And that the prevention of farm and home accidents rests in increasing the amount of emotional security in the young people of the country. The State of Kansas has package lectures developed where local communities such as Farm Bureau groups or other units interested in safety can receive talks by doctors or health and safety experts on this problem. It seems that this might be a good subject for exploration by the Michigan State Medical Society Committee on Safety.

A lively discussion developed on the Family Responsibility for Health Program. It can be summarized by saying that most of the delegates there at the meeting were interested in improving medical services. As usual, this meant the obtaining of more physicians for the areas which are in dire shortage of medical coverage. Also it seems that more emphasis should be placed on educating the family unit in some of its own particular responsibilities regarding medical care and utilization of doctors. It seems to me that this would definitely be a field for the college extension services to work with the Michigan Medical Society in improving medical-laity relations.

The remainder of the meeting was devoted to general subjects of local situations and how the local groups solved those problems. In fact, it was re-emphasized that this Rural Health idea is simply devoted to the idea that it can only accomplish its goals by the combined efforts and initiative of local citizens working on local levels facing their local problems. It is not a dictatorial theme in any sense of the word.

Once again, I would like to thank the Council of the Michigan State Medical Society for allowing me the privilege of attending this meeting and also to participate in it at Milwaukee. I am convinced that in this type of endeavor is the real hope for improving medical services and medical care for the citizens as a whole. If we could only get all segments of the medical profession to have the enthusiasm that is manifested at these meetings where the lay people interested in health and the doctors interested in giving them that health come together for a meeting of the minds, I'm sure that most of the criticism that falls on Medicine's ears would disappear within a very short time.

BROOKER L. MASTERS, M.D.

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AMA Washington Letter

THE MONTH IN WASHINGTON

For the first time in many years, there is a strong possibility that Congress will enact legislation providing federal grants to medical schools. Unlike most bills of the past, which would have given the schools money for salaries and other operating costs, the bill getting most attention now would give money only for construction and equipment.

Action first came in the Health Subcommittee of the Senate Labor and Welfare Committee. Senator Lister Hill (D., Ala.), chairman of the subcommittee as well as the committee, is the principal sponsor of the bill. Senator Hill, long interested in health legislation, was a co-sponsor of the hospital construction act that has been in operation for eight years.

Under the education bill the federal government would grant a total of $250 million to medical schools at the rate of $50 million a year for five years. No school could receive more than $3 million. New schools would receive 50 per cent of construction and equipment costs (up to $3 million limit), but existing schools would receive only one-third, unless they agreed to increase freshman enrollment by at least 5 per cent. If they wished, schools could set aside 20 per cent of the federal grant into a permanent endowment fund, with earnings to be used for maintaining the building and equipment.

Nearly a score of medical school deans appeared before the Hill subcommittee to urge approval of the bill. Also supporting it were the American Medical Association and the American Dental Association, the latter on condition that dental schools also be included. There were no opposition witnesses before the Hill subcommittee.

The AMA's witnesses were Drs. F. J. L. Blasingame, a Trustee, and Walter S. Wiggins, associate secretary of the Council on Medical Education and Hospitals. Dr. Blasingame reviewed efforts of the Association since its founding to improve medical education. He cited evidence to show that medical training in this country now is the best in the world, and that the supply of physicians is increasing at a faster pace than the population.

Dr. Wiggins urged the subcommittee to make two changes. He asked that the financial inducement offered for increased enrollment be dropped, as it might cause some schools to take in more students than they could train properly, a fear that was reflected also in the testimony of some of the medical school deans. He also said the AMA recommended that the law require that six members of the Council on Medical Education be "leading medical authorities."

In the House, the Interstate and Foreign Commerce Committee, facing a heavy schedule of hearings on other bills, was slow to take up the medical education bill. But there, too, its prospects are good, particularly as the bill is sponsored by Chairman Percy Priest (D., Tenn.), whose role in medical bills compares with that of Hill in the Senate.

It appears now that Congress also is willing to go along with the Defense Department once again and extend the doctor draft act for another two years. It is scheduled to expire next June 30. The AMA opposes an extension, maintaining that a more attractive military medical career and better use of uniformed physicians would take care of the services' need for experienced specialists and administrators. The department's main argument for an extension was the need for these older men. Before reporting out the bill, however, the House Armed Services Committee made one significant change. It rewrote the bill to exempt any physicians 35 years or older who had applied for a commission at any time in the past and had been turned down solely because of physical condition.

Also moving ahead on the legislative course is a bill to continue the $100 per month equalization pay for physicians and dentists in uniform. At hearings before the House Interstate and Foreign Commerce Committee the AMA supported the special pay extension, but objected to one provision. The bill originally would have withheld the $100 from men with an obligation under the regular draft unless they agreed to serve for more than the two-year draft obligation. The House Committee eliminated this section. As the bill went to the House, it provided that all commissioned medical and dental officers receive the special pay.

Still undecided was the fate of a Defense Department's bill for medical and dental scholarships. Scholarships would cover subsistence as well as all school expenses. A student receiving aid for a year or less would have to serve on active duty for an extra year; if the scholarship were for more than a year, he would have to spend three extra years on active duty.

At this writing Congress continues to show no particular interest in reinsurance of medical insurance plans, a bill that the administration considers important. Nor have hearings been scheduled yet on the No. 2 administrative bill, that providing federal guarantee for mortgages on such health facilities as hospitals and clinic.

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Editorial Opinion

FRONT LINE VOLUNTEERS OF THE ANTI-POLIO PROGRAM

By Monday, all of Detroit's first and second graders will have received their first Salk polio vaccine shots. This is a remarkable achievement. Some cities have not even begun the immunization process.

Credit for the smooth functioning of Detroit's "Operation Ouch" goes to Dr. Joseph G. Molner, city health commissioner, and his department.

What should not be overlooked, however, is the gratitude which not only Detroit but other communities owe to the thousands of doctors giving generously of their time and services without charge. The program would be slow and selective except for their voluntary participation in the public endeavor to stamp out polio. We know we speak for parents everywhere when we say thanks. —*The Detroit Free Press,* April 23, 1955.

BILLY ROSE SAYS

"For my dough, the most important people in the world are doctors . . .

"If you cut yourself, if something starts biting at your insides, if your kid breaks out in spots, whom to you holler for?

"Your Congressman? The President of your bank? The Secretary of War? Not on your tintype. You send for the man with the little black satchel . . .

"When I was a kid, I had scarlet fever, and they tacked up a sign on my house and nobody could come near me. But a small gent with a black bag walked right in . . .

"I remember asking my mother, 'Can't doctors catch scarlet fever?' She said they couldn't—but she was fibbing. The list of doctors who were killed by the bugs they were chasing would stretch from here to Valhalla . . .

"Of course, the great standouts of medical science don't need any ballyhoo from me. But the doctor who rides around in that 1947 Chevvy could use a little applause. In a civilization that rates a guy by how big a check he can write, the doctor knocks his brains out for less than we pay a bricklayer or a plumber. Sun or slush, he's on tap if you're in trouble. Twenty-four hours a day he stands ready to stop what's hurting you.

"To me that's as important as anybody can get."

(Editor's Note: In these times when it seems that so many writers are eager to pounce on any facet of medical practice, and in most cases write only the side of the particular question that is derogatory to the doctor and only rarely present the matter fairly, your Editor felt that this month he would put in the Guest Editor's Page some notes picked up at random that eulogize the doctor. C. C. N.—*Summit County Medical Bulletin,* January, 1955.

POLIO VACCINE CONFUSION AND FACT

(Continued from Page 648)

it illustrates the "anticipatory PR" which was the keystone of the MSMS position from the beginning. The basic elements are these: On April 19, 1954, MSMS scheduled a statewide telecast as one positive way of presenting its viewpoint on polio vaccine to the people of Michigan at a time when sound counsel seemed a necessity. In this telecast the Chairman of The Council outlined certain reservations MSMS held with regard to the polio vaccine field trial. He emphasized at that time that a product with no official certification of safety and potency was to be used; he declared (1) that the field trial was "mass inoculation of selected children as part of a scientific experiment"; (2) that the prerogative of the family physician to determine the immunization procedures for children under his care should not be by-passed, (3) that family physicians should have access to vaccination records of children involved in the experiment, and (4) that timing of the trials collided with the onset of the polio season.

In 1955, thirteen months later, distribution of the licensed vaccine had been halted twice, and the Federal Department of Health, Education, and Welfare made recommendations including (1) that the Public Health Service must be given "every facility . . . necessary additional funds and personnel, to insure maximum precautions in continued testing of the vaccine for safety and potency"; (2) that physicians should keep detailed records of each child vaccinated and the lot number of the vaccine, and (3) that manufacturers keep complete records of the distribution of every lot. Meanwhile the Surgeon General confirmed that it will not be possible to immunize "most children before the peak polio season" this summer.

THE REMARKABLE RESEMBLANCE between these two statements—made a year apart—is immediately apparent, further confirming the wisdom of the MSMS Executive Committee and

(Continued on Page 696)

What They Thought of the 1955 Michigan Clinical Institute, Detroit

Theodore G. Klumpp, M.D., New York City (guest speaker): "It was a great privilege to participate in the 1955 Michigan Clinical Institute. If I succeeded in making a small contribution to the success of the occasion I shall feel well rewarded.

"I think you have every reason to feel proud of the Michigan Clinical Institute. I have attended many medical meetings but I can say in all frankness that I never had the privilege of participating in a meeting that was better organized. The program itself was outstanding, the expressions of hospitality to speakers and guests were most gratifying. It was a pleasure to be with you and the event was one that neither Mrs. Klumpp nor I shall soon forget."

Alexander Brunschwig, M.D., New York City (guest speaker): "I want again to express my profound thanks for the invitation and for the high honor bestowed upon me by the Michigan Clinical Institute."

Leo H. Bartemeier, M.D., Baltimore, Maryland (guest speaker): "It was an honor to be invited, a pleasure to return home, if but briefly, and last, but not least, to have enjoyed another little visit with you."

M. Edward Davis, M.D., Chicago (guest speaker): "Please convey my thanks to the officers of the Michigan State Medical Society for my invitation to participate in this year's Clinical Institute. I enjoyed my visit to Detroit."

T. B. Quigley, M.D., Boston, Massachusetts (guest speaker): "I enjoyed myself thoroughly in Detroit; in particular, Harold Fenech went far beyond the call of duty in taking care of me. I have never encountered a more pleasant host."

Grayson Carroll, M.D., St. Louis, Missouri (guest speaker): "I wish to thank the Michigan State Medical Society for the fruit in my room and fine hospitality, especially Dr. Schroeder's wonderful care of me."

G. M. Wheatley, M.D., New York City (guest speaker): "Please let me express my great appreciation for the many courtesies extended to me by the Society and especially Dr. Wishropp's fine hospitality."

William Dock, M.D., New York City (guest speaker): "The trip and the meeting were most agreeable. Thanks to the kind attention of my host, Dr. Segar."

Cyrus C. Sturgis, M.D., Ann Arbor (honored guest): "I am writing to thank you for the part you played in arranging the dinner last night, which included me as one of the honored guests. For many long years you have served the Michigan State Medical Society faithfully and effectively, and your efforts have contributed largely to the growth of that organization.

It was a great honor to me to receive the plaque and I am most appreciative of the entire affair."

Eugene B. Ferris, M.D., Atlanta, Georgia (guest essayist): "It was a real pleasure to have been with you in your meeting, and I regretted I could not be there for a longer time."

John R. Fowler, M.D., Barre, Massachusetts (guest essayist): "Thank you for the many courtesies shown me on my recent trip to Detroit. Everything at the Michigan Clinical Institute was perfect, including the fine fellowship I enjoyed with my friends and new acquaintances. Your Program was wonderful and the meeting a great success. I shall long remember it. I am looking forward to our next get-together."

H. M. Pollard, M.D., Ann Arbor (honored guest): "I just want to take this occasion to tell you that as one of the participants in the banquet sponsored by the Michigan State Medical Society last month in Detroit, that I was personally most appreciative.

"Frankly, I felt that my justification for being a part of this occasion was rather minimal, but, nevertheless, I enjoyed being included and want to thank you personally for everything you did in connection with this marvelous occasion."

Leland I. Doan, Midland (honored guest): "Just a brief note on my return to the office to try to thank you for the cordial hospitality extended to Mrs. Doan and to me.

"I felt greatly honored to be included in your program and must say the reception to my efforts on the part of the people attending the dinner was very gratifying to me. I just remarked to some of our folks that I think doctors and their wives are the finest group I could meet with."

G. J. Curry, M.D., Flint (honored guest): "This communication is for the purpose of establishing a permanent record of my gratitude to you for having considerable to do with the scroll, and its contents, given to me last Wednesday afternoon.

"I have always valued our friendship together deeply and I hope that we have many more years to see each other.

"Please convey, officially, to The Council and Officers of the Michigan State Medical Society my gratitude for the honor that they gave me on March 9."

S. W. Leslie, M.D., Toronto, Canada (guest): "May I at this time extend through you to the Michigan Clinical Institute my sincerest thanks for affording me the opportunity of attending the 1954 clinics.

"I would like to state that after attending numerous conventions and clinics, in my opinion I have yet to attend one which was so well organized in both presentation and clinic material which could equal the one I recently attended in Detroit. From a G.P. standpoint, I found the subjects to be most interesting and definitely of great future benefit and profit to myself and my patients.

"Looking forward to returning to Detroit next March for the 1956 Michigan Clinical Institute. Thanking you again."

E. T. Sager, M.D., Marion, Ohio (guest): "I am writing concerning the recent Michigan Clinical Institute which I was privileged to attend. It was a very fine Institute and I am happy indeed to give you a few lines regarding its value to me.

WHAT THEY THOUGHT OF THE 1955 MCI

"I attended the Michigan Clinical Institute this past March because I had attended the previous one in 1954 and received so much valuable, practical help in my practice as a general practitioner in the medical field. The Institute was so all-inclusive because it took in the general medical and surgical field showing the recent developments in all branches of medicine. It was not too highly specialized, as many conferences are, to be of real help to the doctor who still is known for his general practice and as a good family physician.

"The exhibits were wonderful and quite self-explanatory. The Winthrop Progress Report of Medicine dating back to 1900 was excellent and one of the best histories of the development of medicine I have heard."

R. F. Staudacher, Chicago (guest): Thanks for your wonderful hospitality and the chance it gave to meet and greet old friends. 'Your' meetings are always something to be marveled at."

M. Lucille Myers, R.N., Detroit (guest): "We would like to express our thanks to your society for the privilege of holding our 1955 Operating Room Nurse Conference in connection with the Michigan Clinical Institute. Many courtesies were extended to us by your association, the Michigan Clinical Institute, and William J. Burns. In short, we were made to feel most welcome.

"Many thanks also for sponsoring two of our speakers. This assistance was of great help to us.

"We shall anticipate other such good relationships with your organization in the future. If we can be of any service or assistance to you in any way, please call upon us."

Vernon C. Mossman, Port Huron (guest): "As a member of the Michigan Pharmaceutical Association. I accepted your invitation to attend your Clinical Institute, March 10.

"The day was spent visiting the exhibits and listening to your program of fine lectures.

"I wish to thank you for your thoughtfulness and kindness to offer such courtesy."

Morton Hack, Detroit (exhibitor): "Just a note of appreciation for the best Michigan Clinical Institute ever! The attendance was not only large, it was interested. The exhibitor can tell if a meeting is stimulating to the doctors, there is that ineffable something which is exuded, shines from their countenances. This meeting had it!

"Incidentally, I was never so worn out from a three-day meeting—never so many interviews."

STUDENTS VISIT RESEARCH LABORATORIES

Members of the junior class of the University of Michigan Medical School visited Eli Lilly and Company, April 6-9, 1955. While guests of Lilly's, they inspected the Lilly Research Laboratories and toured pharmaceutical, biological, and antibiotic production facilities.

John L. Kihm, class representative, is sixth from the left in the first row.

Olga C. Budds (first row, fifth from left) and Jean D. Golden (first row, seventh from left) are members of the class. Other women in the picture are students' wives.

Walter H. Stein, Lilly representative in Ann Arbor, accompanied the group to Indianapolis. A 1954 graduate of the University of Michigan, he is fourth from the left in the first row.

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The Doctor in Civil Defense

By Lawrence A. Drolett, M.D.
Lansing, Michigan

CIVIL defense in this country becomes a very serious problem and responsibility of the doctor of medicine. While I realize that the public at the present time is very apathetic about civil defense, which comes about either by an unwillingness to recognize the impending dangers at hand or the fact that this great nation of ours has never been subjected to the severe catastrophes that have visited European countries, nevertheless, it is our duty as physicians to be prepared to render a heroic service to the people of our nation in the event of a disaster, either of local or national significance.

At a recent meeting in Chicago, of national civil defense co-ordinators from Indiana, Illinois, Michigan, Wisconsin and Minnesota, two days were consumed in discussing the problem on how the medical forces were going to function in the event of an H-bomb disaster. Some time was spent discussing what would happen in the event of a local disaster, such as a fire, flood, et cetera. After listening to various government officials and various medical co-ordinators from local communities, states, and national civil defense organizations, it becomes apparent that we, at the present time, have a super-human task to do, in face of great odds, to bring the medical profession up to date to cope with such a possibility. I am proud to say that Michigan was the best represented of all the areas, and my impression was that we in Michigan, at the present, are temporarily better organized than other areas with the exception of the city of Milwaukee. Still, there is much heavy work to be done, much co-ordination to be accomplished.

The Milwaukee plan is very well conceived and very well organized, in the event that Milwaukee should become a target area, to evacuate the population of that area and set up emergency medical centers in the regions adjacent to and removed from any bomb area site. They have made arrangements with surrounding counties for temporary hospitalization and organization for treatment of patients for definitive medical care, and their keen interest in their problems involving the population of that city is highly commendable.

I can write locally for our setup in Lansing, Michigan, and can state that the medical profession is tentatively organized to cope with a local disaster and needs only more co-ordination on a state level to be able to assist and be of service not only to the local community but in a well-organized well-thought-out plan for state co-operation, in the event that such a target area might be Detroit or the surrounding metropolitan area. The Ingham County Medical Society has offered the service of its former Disaster Relief Committee which has been accepted by the local civil defense organization.

Briefly, the plan consists of, first, a Medical Co-ordinator who will be in charge of co-ordinating all medical services in the county in the event of a disaster; second, a well organized Field Group of Doctors who will proceed to the immediate scene of the disaster and render such emergency first aid medical care as will be necessary, and third, well-organized hospital groups and teams, consisting of surgeons, internists and anesthetists who will immediately proceed to pre-assigned hospital destinations. There they will proceed with

the task of, first removing from the hospital all convalescent patients who can be safely discharged either home or to other medical facilities, and second, getting ready to receive new casualties who will be admitted by the Field Group. To this Group are assigned physicians and surgeons who live in the area closest to their assigned hospital. At present, we have four available hospitals to which these men will proceed, where definitive medical care can be given to the victims of the disaster by trained medical specialists working in teams.

The Field Group, besides responding to the scene of the disaster, have four immediate surrounding township fire stations to set up as emergency field collecting stations. We have stockpiled OCD supplies in these various localities to give temporary care for casualties, and, in addition, the county medical society has furnished three disaster relief trunks, two of which are in the emergency room of both large hospitals and the third one at the headquarters of the fire department. These latter are fully equipped with surgical dressings, gowns, rubber gloves, sterilized emergency field supplies equipment, 7 units of plasma, and enough narcotics to last for a period of several hours. All this equipment is inspected annually and replaced and re-sterilized and can be brought to the field of the disaster within a few minutes. These temporary supplies should aid in an emergency for a period of from one to six hours, giving time then to organize new lines of supplies and also for the Office of Civil Defense to move in and aid in our program.

We have been aided in our emergency field work by co-ordination with the local county Civil Defense Office in having set aside a system of two-way radios, which will be for the exclusive use of the doctors, manned by the amateur radio operators in the county. A powerful portable field unit can be installed and set up anywhere in the county and, by way of portable two-way transmitters in the automobiles of the amateur radio operators, will afford communication from the center of the disaster to any hospital or any field unit that the medical co-ordinator so designates. It has been my happy experience that the local county Civil Defense Director has been more than willing to co-operate and assure himself of adequate medical care by furnishing us all the material that he possibly can, and it becomes our duty to get deeply interested and reassure him by action that we are more than willing to co-operate with him.

From my vantage point, the big necessity that is seen now is the organization of the medical force of the entire state and particularly of the heavy industrial area of Michigan, under the co-ordination of a full time civil defense medical director to train and instruct, so that should a disaster strike an area such as Detroit, then Ingham County, Jackson County, Calhoun County and other neighboring counties could move into the surrounding area with field units and trained medical experts and set up temporary hospitalization and medical care for the striken area, assuming that this area, in the event of an H-bomb, will be completely wiped out and of no value whatsoever. This was the feeling that I gained from the meeting in Chicago, that we, the doctors of medicine of Michigan, are ready and willing, and what we need is organizational co-ordination. I am sure that, as in the past, we will come to the front and do a justifiable job in the event that such an unpredictable disaster should occur. There seems to be much hue and cry in other areas that nothing can be done for lack of interest and funds on the part of the Federal government. While that may be true, it is my belief that in the event of such a disaster, this is going to be the job and the task of the local citizens in the local area first, to render first-aid and medical care to stricken people, and the kind of job we are organized to do is either going to reflect credit or devastating criticism upon our profession. I believe that a well-organized meeting between the State Civil Defense Director and the Committee on National Defense of the Michigan State Medical Society, with some constructive thinking and well-thought-out projection is in order. I also believe that our new State Civil Defense Director, C. F. Van Blankensteyn, will welcome such a meeting to find out just where the doctors of medicine stand and also to stimulate our interest in this endeavor in which we should be leaders. Let's move before it is too late.

Psychiatry and the General Practitioner

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THE subject of this talk may suggest that I propose to discuss the fact, now well recognized, that many physical complaints and symptoms reflect the emotional stresses incident to everyday problems of living, particularly from feelings that arise under difficulties in living either with ourselves or with certain people with whom life throws us closely. The general practitioner now recognizes however that many physical complaints formerly characterized as "functional" really arise from the fact that chronic emotional states may stimulate the vegetative nervous system with resulting disturbance of physiological functions which, if persistent, tend eventually to produce pathological changes. Frequently 30 per cent of his practice will consist of patients who present symptoms that have no organic basis but arise from life situations that provide no emotional satisfactions or ones that give rise to anxious tensions, feelings of hostility or guilt, to bottled-up resentment, smoldering disconent and other disturbing emotions.

Instead, therefore, of discussing psychosomatic medicine I will present some of the basic principles of psychiatry. I realize that the recent graduate will find this boring because it is "old stuff" that was better presented in medical school, and the older practitioner may find it equally uninteresting because it is theoretical and lacks objectivity, measurability and other demonstrable evidence exacted by science.

First, what is psychiatry? Perhaps it can be defined as that branch of medicine which deals not only with the clinical manifestations and treatment of disturbed thinking, feeling and behavior but also with the influences that gave rise to these disturbances, and how these influences operated to produce symptoms that although apparently meaningless have nevertheless a real meaning and serve some purpose in the mental and emotional life of the patient. It will be noted that in this definition there was no mention of the word "mind." There need not be any objection to the use of that word if it is used as a collective designation for certain functional activities of the organism, as one aspect—the psychological aspect—of its functioning, and not a metaphysical entity having an existence parallel with the body. The dichotomy which is implied by mind and body does not exist in the organism. They are inseparable expressions of life itself, two different aspects of one fundamental unity of biologic functioning which we separate only for convenience of discussion.

Sometimes psychiatry is spoken of as the branch of medicine which deals with such disordered and undesirable functionings of the personality as disturb either the subjective life of the individual or his relations with other persons or with society. But, what, you will ask, do we mean by personality? Perhaps I can best define this by an analogy. It is obvious that processes of maturation and development of the body go on from the time the organism is formed by the fusion of male and female germ cells until adult maturity has been reached. At any time during this biological development noxious factors may limit the growth of the organism, produce malformations or impair the functioning of an organ or of the entire living being. Each person, therefore, has an anatomical structure conforming in general to the species pattern, yet unique in certain details. Likewise the human being gradually develops enduring patterns of temperament, intelligence, beliefs, desires, motives, character and adjustmental methods that give him an individual uniqueness. The distinctive whole formed by the integration of these relatively permanent patterns may be spoken of as personality and its maturity attained only through successive stages of maturation.

Attention was called to the fact that during biological development of the organism noxious factors may limit or distort its growth or impair its functioning. Likewise arrests or deviations may occur during development of the personality. Issues at one developmental level must be dealt with fairly conclusively before those of a higher level can be managed successfully. Each stage of development, too, should be characterized by patterns of feeling and thinking appropriate to it. To return to the definition of psychiatry from the standpoint of personality. Psychiatry may be briefly defined as the study of the pathogenesis and

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pathology of the personality and the application of therapeutic techniques to its disorders.

Of all experiences and factors those that have the most determinative influence upon the growing, plastic personality of the child are those that spring from the emotional, personal, interacting relationships between it and members of his family. The external shaping of the personality starts with parent-child relationship, particularly with that of the mother and child. Many consider a wholesome mother-child relationship as vital for emotional growth and healthy personality development as are vitamins for physical growth. Essential as a foundation for future healthy personality development the child must have a feeling that he is wanted, loved and enjoyed by his parents. He should not, however, remain dependent on a mother for maintaining emotional security.

Quite early in the growth of the child's personality some psychological processes come to function on a conscious level while others operate on an unconscious level and exert their influence on the individual's life without his knowing of their existence. While further development of the personality continues to be directed from both of these levels, its pattern, whether rigid or neurotic, or flexibly adaptive to changing external realities, will depend largely on the extent to which psychological and emotional needs from these two levels pursue incompatible goals and to what extent unconscious motives and objectives dominate the personality. The type of personality pattern the individual works out for himself in his effort to meet the stresses of life will be influenced by many things. Among them will be the nature and number of the psychological defenses which he constructs against tendencies which he cannot consciously acknowledge or against feeling-attitudes toward persons who have occupied key positions in his life, particularly during childhood. If one develops a multiplicity of such mental defenses designed to reduce tension and anxiety, a constricted type of personality results. If these defenses become pathologically exaggerated or disorganizing, they eventuate in the neurotic or psychotic personality.

Since psychiatry is a branch of medicine that deals with the mind, its pathology cannot be explained in terms of disturbed biochemistry, degenerative processes or the usual ones seen daily in many other branches of medicine. Prior to the time of Adolf Meyer, professor of psychiatry, Johns Hopkins University, from 1910 to 1941, psychiatry had not advanced much beyond the descriptive stage. There seemed to be certain groups of symptoms that were found in association. It was thought that since these symptoms were associated together they must arise from a definite disease entity. Meyer took a broader view than that. Since man is a biological organism, he said, one should approach the study of man from a biological standpoint and consider his mental life as but one aspect of his biological functioning, yet one that is influenced by all the factors that act on man as a biological organism. Meyer stressed the concept that mental expressions of life are no less biological than are physical ones and that the psychiatrist should study man's mental expressions as an interaction of an individual organism with its life situations. He insisted that since the patient is both a biological and social organism one should study not only the organic aspects of the individual but also the sociological, cultural, experiential and psychological aspects of the patient. Mental illness, to Meyer, was a response to the special, complex life situation in which the individual is placed. He taught that one must consider the whole setting and uniqueness of circumstances in which the mental disorder occurred and that the mental disorder should be looked upon as a reaction or mode of behavior, a faulty adaptation understandable in terms of the individual's life history.

Meyer's contribution was one of the utmost importance. Its naturalistic, biological approach to a study of the personality, including its psychological aspects, was more comprehensive and meaningful than any previous one. In the opinion of most psychiatrists, however, it should be supplemented. It is generally felt that Meyer did not realize the extent to which psychological activities take place without conscious recognition. It is now pretty generally accepted that one has many impulses, desires and emotional responses which are inaccessible to his introspective observation and are therefore termed "unconscious." Let me illustrate how some mental processes operate without conscious awareness and yet as if with designed purpose. During the course of its evolution every species has developed various means and mechanisms whereby it may obtain an adjustment to the life conditions it must meet. Many butterflies, for example, develop a protective coloring whereby they so stimulate the appearance of

the surface on which they rest that they escape detection by their enemies. Since adaptation is the very essence of life, it is not strange that man as the most highly developed species has developed not only anatomical adjustments which protect him structurally or physiologically in respect to his environment but has also evolved psychological devices that give him emotional support and protection. These devices or mental mechanisms, as they are called, afford the individual a sense of security, preserve his self-esteem, gain a desired recognition of himself, provide defense against perturbing anxiety or meet other emotional needs. The self-conscious personality with its intense need for a sense of security and self-esteem evokes mechanisms of a protective nature as instinctively as self-preservation prompts the avoidance of approaching physical danger. Just as the body through its physical and biochemical processes strives to maintain a physiological equilibrium or homeostasis, so the personality through automatic and unconscious psychological processes seeks to maintain an emotional or psychological stability.

When we come to examine the various adjustive techniques by which individuals strive to protect the personality, to satisfy its emotional needs, to establish and maintain harmony among its conflicting tendencies, to reduce tension and anxiety arising from unacceptable impulses that must be counteracted or restrained, or to modify reality in order to make it more tolerable, we find these techniques fall into rather definite types unconsciously selected to meet the personality needs. We see the individual use the same techniques, the same defenses automatically employed over and over in the various situations to which he must adjust. Please understand that a moderate employment of many of these techniques does not by any means indicate that the one employing them is suffering from mental disease. In many of them are to be found processes that govern all of us and give outstanding characteristics of many well adjusted and useful personalities. These intrapsychic operations acting without conscious recognition on the part of the individual become inextricably woven into his behavior pattern and will be found to be operative in a variety of mental manifestations ranging from character traits through slight deviation from the norm to profound psychic disturbances.

Many of our concepts concerning these mental mechanisms by means of which people deal with their problems are too technical for presentation here. I will, however, mention a few of the simpler forms and illustrate how they act. One of the common techniques is that known as compensation. Physiological and physical compensations are phenomena which the internist and the surgeon see daily. If a valve of the heart cannot perform its function properly, the heart muscle hypertrophies in order that additional force may be available to compensate for the insufficient delivery of blood to the tissues that would otherwise follow. Such a compensation represents an attempt of an organ to adjust to a physiological defect and inadequacy. Similarly the organism as a whole, in distinction from its component organs, by compensating for its inadequacies and imperfections often attempts to secure the recognition which it craves. Such compensations may easily become exaggerated and unwittingly betrayed by one's behavior. The person of small stature but with aggressive self-confidence is an example of overcompensation familiar to all. The need for prestige seems to be one of the fundamental ones of the personality. Measures of enhancing our self-feeling and of covering up our deficiencies are widespread and vary from the simple "showing off" seen daily on the playground or the pretentious display observed in "Peacock Alley" to the formation of delusions of grandeur. A boy who was so tall, awkward and ungainly that he had always been extremely self-conscious of his figure and manner enlisted in the army. (Probably without consciously realizing it he had been prompted to enlist because the military uniform and a certain glamour connected with military service seemed to offer hope of relief from the unpleasant sense of being different from others.) Here he soon became an object of raillery because of his clumsiness in attempting to execute drills. After having struggled in vain for adeptness, the boy was placed in the "awkward squad' where he naturally felt even more self-conscious and more painfully aware of his deficiencies. The indignity suffered by his self-esteem was too great; the need of his personality for a more satisfying recognition and for a sense of security exceeded its limited resources, and he therefore constructed a fictitious substitute by developing the belief that he was a major general. He was no longer the awkward soldier unable to compete with his peers but was

their commander and directed affairs of great military importance.

Another defensive psychological device that operates without awareness is that known as projection. One may see this acting daily to a limited degree among his associates and to a psychotic degree in paranoia and the paranoid psychoses. By this mechanism one directs outward and attributes to others his disclaimed and objectionable character traits, attitudes, motives and desires. One constantly meets people who discover in other persons the very same faults which are the weak points of their own character, utterly failing to recognize the fact that they themselves are really the ones who possess the despised traits and motives. Feelings of guilt may be alleviated if one is able to cast the blame for his shameful tendencies or wishes onto the outer world, leaving himself guiltless. As a further defense against the feelings which would naturally be aroused and against which he must protect himself, he may respond with hostile and aggressive behavior toward the person who is the focus of his projection.

During World War I an American soldier in order to escape from a highly dangerous situation shot himself in the foot. He was at first treated in an army hospital in France and later transferred to the States where the self-inflicted wound healed slowly. The retrospective sense of guilt created by his cowardice and dereliction was alleviated psychologically by projection. The delay in the healing of the foot was due, he began to believe, to neglect by his physician. The soldier felt no self-reproach since it was not he but the physician who was culpable. Soon he secured a gun and shot but fortunately did not seriously wound the physician. He, of course, was quite unaware that the attempt he made on the life of the physician was an effort to destroy qualities of which he was the actual possessor.

There are various other mental mechanisms that may be operative in the production of personality disorders, in the neuroses and in the psychoses, but many of them are more complicated in their operation and less transparent in the purpose they serve. All of them, however, represent automatic protective devices by which the human personality attempts to repair its defects, meet the demands of life without and of instinctual drives within, attain a sense of security, reduce tension and anxiety, preserve its self-esteem and satisfy its emotional needs. Many blind spots, many self-defensive attributes of character, personality façades, many attitudes and beliefs, much behavior seen in every day life, as well as many symptoms of the neuroses and psychoses, may be explained and formulated in terms of these mental mechanisms which should be regarded as reaction patterns occurring in the setting of the person's life experience. Pragmatically they should be regarded as pathological but are nevertheless quite understandable. Although varying with each individual, many of them contribute to the personality features and characteristics of the so-called normal as well as those of the mentally disordered person. The pathological defense mechanisms may merely produce rigid, constricted personalities, too impoverished emotionally to enjoy the positive aspects of living, or they may so disorganize the personality that it cannot tolerate reality.

Please do not think that I have overlooked the fact that some mental diseases are caused by or associated with impairment of brain tissue functions. These disturbed mental states are spoken of as organic reactions, and the symptoms are caused by some agent or process which has impaired the functions of brain tissue with resulting weakening in capacity for intellectual functioning, manifested principally by confusion, impairment of orientation, of memory, difficulty in grasping the meaning of questions and of facts and a disturbance in judgment. Some of these organic syndromes are acute and reversible, as in toxic states, others are irreversible and progressive, as in senile dementia.

Most mental disorder, however, is not a disturbance in the function of a single organ, like the brain, but the maladapted and disordered behavior of a particular individual. Physiological disturbances of the brain cannot alone explain disturbances in belief, mood and behavior. As indicated, there is no functional imperfection in the nerve tissue of the brain; rather does the mental disturbance represent the reaction of an individual personality to its special life situation, including its social and emotional experiences. Such disturbances are described as psychogenic, i.e., the sources from which they sprang are "mental" and are related to emotional needs, guilt-producing situations, irreconcilable desires, disturbing interpersonal relations and other emotional stresses and tensions.

Earlier I commented that one often notes certain adjustive techniques, certain psychological de-

fenses, as it were, so consistently employed that they are woven into the individual's personality characteristics and particular traits. If later he becomes psychotic, the form of his psychosis suggests that it is but an exaggeration or caricature of his previous personality and that in general the same defenses and psychological techniques are being employed as during his prepsychotic life. The same psychological theme, as it were, runs through personality, character traits and psychosis. This is true of many psychoses but is perhaps particularly noticeable in involutional melancholia in which a certain general type of personality make-up and habits will be found in the prepsychotic life. A review of the patient's previous personality and temperament often shows that she has been an inhibited type of individual with a tendency to be quiet, unobtrusive, serious, chronically worrisome, intolerant, sensitive, scrupulously honest, frugal, even penurious stubborn, of stern, unbending moral code, lacking in humor and overconscientious. Usually she has been perfectionistic, exacting in her own standards of behavior, prudish and prone to feelings of guilt. Often the patient's interests have been narrow, her habits stereotyped, she has cared little for recreation and has had but few close friends. Frequently the patient has been a loyal subordinate, meticulous as to detail rather than an aggressive, confident leader. (Many have been fidgety, fretful, apprehensive persons. Others have been characterized by caution or indecision.)

The age at which the psychosis develops is one when adjustments to new situations and circumstances are no longer easily made. Perhaps life has not brought either the success or satisfaction that hope had cherished. At this period thare is a more or less conscious recognition that early dreams and desires cannot now be fulfilled, that the zenith of life has been passed and that ambition and life's forces are waning. The fact that opportunity no longer exists for repairing old errors or achieving new success creates a sense of frustration and increases the feeling of insecurity. In women loneliness or fear of a loss of physical attractiveness may be a contributing factor. Perhaps old friends are beginning to die, or children to whom the patient has devoted her life are leaving home and are becoming preoccupied with their own lives and families. She may feel that she is no longer needed.

The manifest symptoms of the psychosis are often preceded by a period during which the patient exhibits hypochondriacal trends, becomes irritable, peevish, pessimistic, is perhaps suspicious and shows a disinclination for effort. She is unable to concentrate and shows doubt and indecision. The patient complains of distressing sensations in the head, eats poorly, loses weight, worries about health or finance and become apprehensive and restless. The depression increases and the patient becomes agitated, anxious, expresses delusions of sin, unworthiness, disease and of impending death. The patient's appearance becomes one of extreme emotional pain and misery. The fear, apprehension and agitation increase. Not infrequently ideas of suicide are entertained and perhaps attempts at ending her life are made. It will thus be seen that we must not think of the involutional depressive reaction as a circumscribed disease entity resulting from clearly defined bodily changes but rather that we have to do with an individual whose mental disorder is the logical but unfortunate culmination of lifelong personality tendencies.

I am somewhat troubled by the fact that this presentation has had very little or no material that has been of clinical value. I trust at another meeting someone else will present that important aspect of psychiatry. It occurred to me, however, that perhaps on one occasion a few of you might be interested in some of the ways in which the mind operates in all human beings, both in those who are subjectively and socially well adjusted and are therefore called healthy in mind, and in those who are not so adjusted and are therefore called mentally ill.

Dysphagia is the most significant symptom of esophageal cancer. Approximately 80 per cent occurs in males.

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Early diagnosis of esophageal cancer is possible only when a cervical, retrosternal or epigastric abnormal sensation is not regarded as a neurosis.

Esophagoscopy is indicated in every patient complaining of difficulty in swallowing, in patients over forty years of age when the cause of difficulty is in doubt.

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Gastric polyposis is rare but is considered precancerous.

Intestinal Obstruction after Gastric Surgery

By Roland P. Reynolds, M.D.
and
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INTESTINAL obstruction is not an uncommon occurrence following gastric surgery. There are many operative procedures which may be performed upon the stomach. Each may present some particular hazard toward small bowel obstruction because of the anatomical changes that were made in the stomach or duodenum. We shall concern ourselves in this paper with only three of the most common surgical gastric procedures. These are: (1) closure of a perforated ulcer; (2) gastrojejunostomy (anterior or posterior), and (3) gastric resection The gastrojejunostomy and gastrectomy may be performed with vagotomy.

Intestinal obstruction is an uncommon sequeli following the surgical treatment of perforated peptic ulcer whether duodenal or gastric. The obstruction may be divided into two main groups. In the first group would appear the non-specific type of intestinal obstruction following closure of a perforated ulcer. By non-specific we mean that this type of bowel obstruction might occur after any abdominal operation as a result of adhesions, plastic exudate or peritoneal infection. The specific type of bowel obstruction after closure of a perforated peptic ulcer is that type which is due to that specific procedure directly.

In the non-specific type of small bowel obstruction a knuckle of bowel may become adherent to the incision in the anterior abdominal wall and result in obstruction, or a loop of bowel may become adherent to the abdominal wall with a volvulus effect, or a loop of bowel may slip through or around a loop so attached resulting in a small bowel volvulus of varying extent. There are many and varied types of intestinal obstruction due to adhesions which form following any abdominal procedure and the closure of a perforated ulcer is not an exception.

Specifically the closure of a perforated ulcer would seem to carry little or no hazard in the causation of small bowel obstruction. This is not the case. A knuckle of bowel may become adherent to the point of closure and so become obstructed. This is particularly likely to occur if long "tails" are left upon the suture used in the closure. If a live loose-attached omental graft is brought up and sutured over the point of perforation, a loop of bowel may slip through the loop so formed and thus produce intestinal obstruction. The closure of a perforated ulcer by purse-string or plicating sutures may so narrow the duodenum or pylorus that stenosis results. In addition to these, the not infrequent subphrenic or pelvic abscess which results from a perforated peptic ulcer may cause bowel obstruction. This may be of three main types: (1) the abscess may produce intestinal obstruction by the edematous changes or a plastic exudate upon the bowel in contact with it; (2) the abscess may be large enough to cause bowel obstruction by compression; (3) as a late sequeli of an abscess violin-string adhesions may form which cause bowel obstruction years later. In addition to the above types of mechanical obstruction, a paralytic ileus is a usual accompaniment of all intra-abdominal infectious processes.

Posterior wall ulcers may penetrate into the pancreas. Although this does not generally result in a diffuse peritonitis, it may cause paralytic ileus as a result of infection in the lesser peritoneal cavity or a pancreatitis of varying degrees. The clinical findings in a case of this type would be those of paralytic ileus due to the penetration of the posterior wall ulcer into the pancreas. The treatment in a case of this type should be conservative if a diagnosis is made clinically. In those cases in which a diagnosis is not made clinically and surgery is performed an opening should be made through the gastro colic omentum and the perforation closed. If the patient is seen early enough gastric resection has been advocated as definitive surgery. Generally cases of this type had best be treated by suction and intravenous alimentation.

Gastroenterostomy and sub-total gastrectomy are by far the most common operative procedures upon the stomach. Of the two, partial gastrectomy is the most common. Each of these procedures, however, carries with it the danger of small bowel obstruction.

The first case in which obstruction and intestinal loop detachment occurred following gastroenterostomy was the case described by Kehr in

1899.[6] This was only 18 years after the first gastroenterostomy had been performed by Wolfler.[14] Although isolated case reports of this type have appeared in the literature from time to time, it still remained a rather uncommon accident. This is especially true in this period in which gastroenterostomy has lost much of its popularity. The type of small bowel obstruction specific to the operative procedure of gastroenterostomy depends to some extent upon whether an anterior or posterior gastrojejunostomy was performed, and in addition whether it was iso-peristaltic or anti-peristaltic.

The most uncommon type of small bowel obstruction is the type described by Hellens and Nummi,[4] in which following an anterior gastroenterostomy with an entero-anastomosis between the loops, some years later it was found that the gastroenterostomy stoma had completely closed. The intestinal loop had become detached from the stomach and had obstructed. A second rather uncommon complication producing small bowel obstruction is due to jejunal prolapse following gastroenterostomy.[11] This occurrence is rather uncommon but by no means rare. Aleman[1] in 1948 reviewed the literature and reported seventy cases of an acute or chronic type to which he added two cases of his own. In an obstruction of this type, the process may be acute or chronic. In some cases the prolapse reduces itself spontaneously and such cases do not require surgical correction. In the acute type of prolapse surgical correction is indicated particularly if the patient is in good condition. In such cases, the gastroenterostomy should be taken down and a partial gastrectomy performed.

If a posterior gastroenterostomy is performed and if the stomach proximal to the line of anastomosis is not well anchored to the opening in the mesocolon, it may tear through with the result that the afferent and efferent limbs of the gastroenerostomy may be so compressed against each other through the small opening that they become obstructed. The signs and symptoms would be those of high intestinal obstruction. The treatment would be prompt surgical correction. Another type of intestinal obstruction following posterior gastroenterostomy may occur. If the jejunum is anastomosed to the dorsal surface of the stomach incorrectly on a horizontal plane, when the patient assumes the erect position the loop of jejunum will tend to twist on its long axis. As a result, the proximal or distal loop may become obstructed at its end. This is particularly apt to occur if the jejunum has become somewhat edematous. In cases of this type signs and symptoms of intestinal obstruction appear within the first ten days. It is imperative that the gastroenterostomy be taken down, the bowel resected, and a new gastroenterostomy properly placed.

In those cases in which an anterior gastroenterostomy is performed, hazards of a different type may occur. If the proximal loop is anastomosed to the greater curvature as a short loop and the distal loop anastomosed to the pyloric side in an iso-peristaltic fashion, volvulus of the proximal or distal loops is unlikely. Retrograde intussusception of the distal loop may occur however through the anastomosis producing intestinal obstruction. A second type of obstruction may result if a loop of small bowel passes into the space lying between the gastroenterostomy in front and the transverse colon behind. Such loops of bowel may slip into this space from left to right or from right to left causing volvulus of the small bowel so internally herniated. Surgical correction as soon as possible is required in such cases because of the marked tendency toward strangulation due to the volvulus.

In cases in which an anti-peristaltic anastomosis is performed by anastomosing a long afferent loop to the pyloric side and a distal loop to the greater curvature side, and if the mesentery is short, it is possible for the mesentery to compress the afferent loop as to produce intestinal obstruction.

Taking down this anastomosis and making an iso-peristaltic type of anastomosis would be the corrective procedure.

Stomal obstruction due to edema, infection or kinking may occur at the opening of the proximal or distal loop into the stomach. If the proximal stoma is obstructed, bile and pancreatic juice will regurgitate into the stomach through the pylorus if patent. If the pylorus is completely stenosed, great duodenal distention may occur. If the stoma of the distal loop becomes obstructed, the line of anastomosis may be jeopardized by the distention of its wall. Serious consequences from proximal or distal jejunal loop obstructions at the stoma are rather uncommon because in most cases the pylorus is patent so that bile and pancreatic juice may

reflux into the stomach in a case of gastro-enterostomy. This can be removed by suction via a Levin tube. This is not the case, however, after a sub-total gastrectomy because the duodenal stump is closed.

A last, but not least important type of small bowel obstruction as a result of a gastro-enterostomy is axial rotation of the jejunum. This only occurs as a result of an error in surgical technique. This occurs when the surgeon begins the jejunal anastomosis on the mesenteric edge and ends the anastomosis on the anti-mesenteric edge. As a result, the jejunal loop anastomosed to the stomach becomes twisted on its long axis undergoing axial rotation and so becoming completely obstructed. Treatment consists in taking down the anastomosis and reconstructing it along straight lines.

Intestinal obstruction after gastric surgery may be of many types. The simplest type of obstruction exclusive of the non-specific variety following any abdominal procedure, is stomal edema.

When we speak of the stoma following partial gastrectomy, we do not refer to the entire gastro-jejunal anastomotic line. We refer only to the lumen of the proximal or distal jejunal loop.[7,8] It should be apparent that regardless of whether one performs a Polya type of anastomosis with a wide stoma or a Hofmeister type of anastomosis with a small stoma, that the true gastric stoma is that opening into which the gastric or intestinal contents are poured, namely, the circumference of the jejunal loop which receives it. In the case of the efferent loop it would be the circumference of the efferent jejunal loop attached to the stomach. Obstruction at this point will produce high intestinal obstruction, whereas obstructions at the stoma of the proximal loop will result in accumulation of bile and pancreatic juice into the proximal loop. This loop having a blind end at the duodenum is apt to result in duodenal stump blow-out with resultant peritonitis.

There are three recognizable types of stomal obstruction. These are in the order of occurence: (1) stomal edema which may be the result of an electrolyte imbalance, either a hypo-chloremia or a hypo-proteinemia; (2) obstruction of the stoma as a result of adhesions or as a result of too high tacking of the jejunal loop to the lesser curvature side of the stomach with a resultant down-drag of the weighted loop causing sharp angulation and obstruction; (3) paralysis of the distal jejunal loop.[9] This is most uncommon. It may occur when the pancreas has been traumatized in the release of a penetrating posterior wall ulcer whether it be gastric or duodenal.

When it has been established that the cause of the obstruction of the stoma is on the basis of stomal edema, the correction of the electrolyte imbalance or hypo-proteinemia results in a release of the obstructing process. Plasma or whole blood may be given intravenously. Ground meat may be given by mouth via a fine polyethelene tube as suggested by Fallis.[2] Constant suction applied to in indwelling Levin tube in the stomach is required. The authors on one occasion treated a patient in this way for 23 days before the obstruction relented and continuity of the bowel was completely re-established. Graham[3] reported one case which he had treated in this fashion for 56 days. If it has been established radiologically that the obstruction is not due to stomal edema but is mechanical in nature, surgical correction is necessary. Lysis of adhesive bands is usually sufficient. In those patients in whom a loop of bowel was tacked too high along the lesser curvature, releasing this loop reduces the angulation and hence also relieves the obstruction.

Paralysis of the distal jejunal loop may occur after sub-total gastrectomy and result in gastro-intestinal stasis. This is an uncommon type of bowel obstruction. Four cases of this type were reported by the authors. In all these patients re-operation was resorted to when conservative measures failed. At the second operation, both the gastrojejunal and the stomal openings were found to be of normal caliber. In each case there was a marked atony of the distal jejunal loop noted. In each case an entero-anastomosis was performed and in each instance the patient expired. It would seem from this experience that the treatment of choice would be long tube alimentation over sufficiently long period of time until the process producing the atony of the distal loop had resolved and peristaltic activity had been re-established. In those patients surgically treated, jejunostomy for purposes of feeding is the procedure of choice.

Volvulus of the stomach may occur at any time following sub-total gastrectomy. This is especially apt to occur if a long loop anterior gastro-jejunostomy is performed. At times an adhesive band or a bridle of omentum may wrap itself around the proximal and distal jejunal loops pro-

ducing a mild partial obstruction. The resultant stagnation of intestinal contents may so weight down the proximal and distal jejunal loops that the stomach undergoes volvulus. In cases of this type, gangrenous changes occur rapidly. Surgical intervention as soon as possible is the only treatment. Volvulus of the stomach may occur in a different fashion. In a review of 425 subtotal gastrectomies performed at Grace Hospital, one volvulus of the stomach was found as a late complication. This patient had been resected several years previously. The stomach had become adherent to the abdominal wall about one-third the distance from the esophageal opening to the line of anastomosis. With this portion of the stomach acting as a fixed point, the distal portion of the stomach and the gastrojejunostomy had undergone volvulus producing a high intestinal obstruction. This same complication may occur following gastroenterostomy.

Adhesions may cause small bowel obstruction after gastric resection by compression of either the gastrojejunostomy or the proximal or distal loops. On occasion, an omental bridle may become adherent to the proximal or distal loops from the duodenum causing bowel compression. On occasion the omentum may pass behind the gastrojejunostomy and sweep from left to right over the proximal and distal jejunal loops obstructing them. Volvulus of the proximal or distal jejunal loops as a result of this latter type of adhesion is not rare. The treatment of this type of case is simple lysis or resection of the omental bridle or band.

Internal herniation may occur following a gastric resection. In the case of a true Polya in which a posterior gastrojejunostomy is performed, the proximal or distal jejunal loops or both may herniate through the opening in the mesocolon. Intestinal obstruction is the usual result of this accident. To prevent this complication the stomach should be well anchored to the opening in the mesocolon. On occasion when the mesocolon is very short, the sutures may pull through with the result that both proximal and distal jejunal loops herniate through the mesocolonic opening and become obstructed. At operation upon cases of this type it may be possible to withdraw the herniated loops of bowel through the mesocolonic opening and anchor the stomach side well to the rent in the mesocolon as well as to the dorsal edge of the transverse colon.

If an ante-colic type of gastrojejunostomy is performed following a gastric resection, it is important to know whether an iso-peristaltic or an anti-peristaltic type of gastro-jejunostomy was done. In the event that an anti-peristaltic type of anastomosis was performed in which the proximal loop was anastomosed to the lesser curvature and the distal loop to the greater curvature, intestinal obstruction of two types may occur. In the first type, if the mesentery of the small bowel is short it may cut into or compress the proximal loop lying behind it and so produce proximal loop obstruction. This results in marked distention of the proximal loop and may result in a blowout of the duodenal stump.[10] A second type of intestinal obstuction as a result of anti-peristaltic gastrojejunostomy of the ante-colic type is produced when the proximal limb twists behind the anastomosis coming to lie between the transverse colon and the gastrojejunostomy producing a volvulus of the proximal limb. The proximal loop becomes tremendously dilated and may become gangrenous because of strangulation or duodenal stump blowout may occur.[13] In cases of this type, if no strangulation has occurred the proximal limb should be tacked to the distal limb with interrupted 000 silk and an enteroanastomosis between the loops performed. If gangrenous changes have occurred, it may be necessary to resect the duodenal stump and the entire proximal limb transplanting the common duct and pancreatic ducts into the jejunum.

Hublin[5] has reported a rather unusual type of bowel obstruction after gastrojejunostomy with enteroanastomosis. Volvulus of the small bowel may occur around the enteroanastomosis producing obstruction. The bowel may also pass between the loops becoming obstructed. To avoid this complication, the two loops both proximal and distal should be sutured together with interrupted sutures and the space between the proximal and distal loops in front and the transverse colon behind should be obliterated by tacking the loops to the transverse colon. Herniation of either the proximal or distal jejunal loops through the gastrojejunostomy may occur producing an intussusception with intestinal obstruction. This is most likely to occur in the anti-peristaltic type in which a long proximal loop is present. It is less likely to occur in the iso-peristaltic type of gastrojejunostomy in which the proximal loop is attached to the greater curvature and the distal loop to the lesser.

The well-known tendency of the intestine to

creep into openings and recesses is responsible for a rather unusual type of intestinal obstruction after gastric surgery. Part of the small bowel may slip into the recess behind the gastrojejunostomy and the transverse colon. Strangulation of much of the small bowel may occur as a result. Generally this hernial opening is so wide that no real herniation with gangrene of the intestine results, except in advanced cases. Passage of intestinal contents through this herniated bowel is blocked with the result that progressive ileus may result. Stammers[14] reported four cases of this rather uncommon occurrence.

Retrograde intussusception is a rare complication of operations on the stomach. A retrograde invagination of the small intestine through the gastrojejunostomy is occasionally found. It has been noted after anterior gastrojejunostomy as well as posterior gastrojejunostomy. Tuomikoski collected twenty-nine cases of this type from the literature and added one of his own. Up to 1951, the number of published cases of this type did not exceed fifty. In one case reported by Hublin this complication recurred two times after gastric resection of the Billroth No. 2 type. The amount of small bowel intussuscepted retrogradely into the stomach is extremely variable ranging from a few inches to as much as two feet. In most cases it may easily be reduced without necrosis. Occasionally necrosis of the intussuscepted loop may occur which require bowel resection. This retrograde intussusception may be acute or chronic. In many of the chronic cases the small loop of bowel spontaneously reduces itself. In the acute case, spontaneous reduction does not occur and surgical correction is imperative. As a rule reduction is simple. Tacking the proximal and distal loops together is usually sufficient as a corrective measure. In those cases in which necrosis of the bowel intussuscepted into the stomach is found, resection and re-anastomosis is required. Intussusception of the proximal loop into the stomach may occur as late as 15 years after a gastric resection with a long proximal loop.

A rather rare and bizarre type of intestinal obstruction described as the "vicious circle" type may occasionally occur. Hublin[5] describes this as occurring after gastroenterostomy or gastric resection. In this type of case, barium is seen to circulate from the stomach through the descending limb through the enteroanastomosis, up the ascending limb and back into the stomach at a very rapid rate. Such patients become nutritional problems. Hublin suggests as treatment the resection of the ascending limb resulting in a Y-shaped gastrojejunostomy. The mechanism involved could be ascribed to wrongly directed peristalsis which does not drive the stomach contents out into the intestine but instead through the enteroanastomosis and into the ascending limb and back through the stomach. Retrograde invagination may be due to peristalsis of this type.

Summary

The non-specific type of small bowel obstruction following gastric surgery will probably always constitute a problem. Little can be done to prevent their occurrence if proper hemostasis, gentleness in handling tissue, avoidance of hot packs and other well-known causes of adhesions are avoided. Stomal edema may be prevented by proper preparation of the patient. Correction of hypochloremia and hypoproteinemia before surgery as well as improving the patient's nutrition will reduce this problem to a minimum. All the types of bowel obstruction that result from a loop type of gastrojejunostomy such as the Polya, Hofmeister, or Billroth No. 2 may be completely eliminated by the simple expedient of avoiding such loop operations whenever possible. The Billroth No. 1 procedure re-establishes the continuity of the bowel without any loop. From this it would appear to be the answer to the majority of obstructions following partial gastrectomy.

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Perforation of the Esophagus

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PERFORATION of the esophagus is a surgical emergency requiring immediate attention. Fortunately most cases are already in the hands of a physician when the perforation occurs so that recognition of the lesion and institution of proper treatment with a favorable outcome is usually possible. Of the fifty cases of perforation of the esophagus reported by Seybold et al[32] from the Mayo Clinic, thirty-three followed instrumentation. The use of the esophagoscope and the Plummer hydrostatic dilator were responsible for the majority of these instrumental perforations. Next in order as the cause of perforation of the esophagus is the swallowing of foreign bodies. Among the intrinsic causes of rupture, a most unusual one is noted in the case presented by Kerr et al[21] of a three-year-old child who bit a filled inner tube. The most common foreign bodies causing perforation of the esophagus are fish and chicken bones. Safety pins are a common cause in infants.

Perforation of the esophagus from extrinsic causes is rare. Among the external causes are trauma, rupture of aortic aneurysm into the esophagus,[5,13] complications following extrapleural pneumothorax[14] and following intrathoracic operations on adjacent structures.[25]

Spontaneous perforation of the esophagus,[1-4,10,18-20,22-24,26,28-30,33,36] practically always occurs in the lower part of the esophagus just above the diaphragm. Anderson[1] in 1952 reported 108 cases of spontaneous perforation of the esophagus with only thirty recoveries and all of the recoveries followed surgery. In the discussion following this paper, Abbott[1] added thirty-one cases, Heroz two, Overholt one, Waterman six, and Fryfogle presented the history of a newborn infant who sustained a rupture of the lower end of the esophagus due to complete obstruction from a congenital diaphragm in the esophagus. Wangensteen (in discussion[1]) does not like the term "spontaneous perforation" and prefers to call the disease "acid-peptic perforations of the esophagus." Samson[30] calls it "post emetic rupture of the esophagus." There has been considerable speculation on the cause of spontaneous perforation of the esophagus. It is said that the usual patient is a middle-aged male, previously healthy, who, following excessive alcoholic intake and vomiting, sustains a rupture in the vulnerable part of the esophagus, i.e., the supradiaphragmatic portion. Many of these patients have given a history suggestive of peptic ulcer.

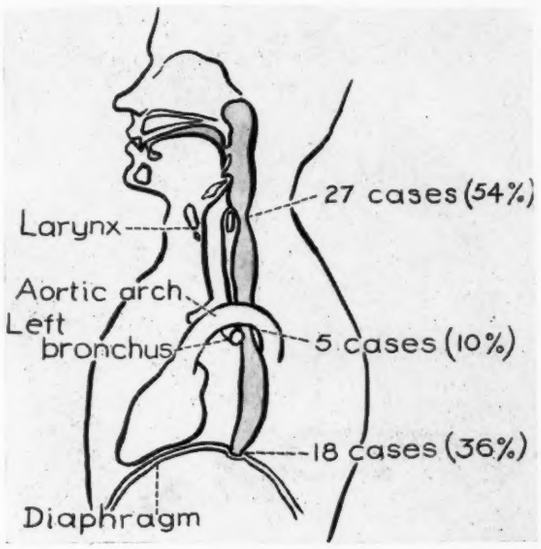

Fig. 1. Location of perforation of the esophagus as reported from the Mayo Clinic.[32] Of the twenty-seven cases of perforation occurring in the cervical esophagus, fifteen occurred at esophagoscopy and seven were due to foreign bodies. The perforations in the upper and mid-thoracic esophagus were due to foreign bodies. Of the eighteen cases of perforation occurring in the lower end of the esophagus, fifteen were due to attempts at dilatation of cardiospasm or stricture.

Perforation of the esophagus following esophagoscopy usually occurs in the cervical esophagus. The pharyngeal funnel narrows abruptly as it enters the esophagus where the inferior part of the inferior constrictor muscle of the pharynx (called the crico-pharyngeus muscle) keeps the esophagus closed. The posterior plate of the cricoid cartilage is held tightly, by the crico-pharyngeus muscle, to the bodies of the sixth and seventh cervical vertebrae. Due to the thinness of the posterior wall of the esophagus, the tonic closure of the esophageal opening and the bodies of the cervical vertebrae directly posterior, perforation of the esophagus here occurs in the

posterior wall of the esophagus. At the time of esophagoscopy, the posterior wall of the esophagus may be traumatized sufficiently to allow a perforation to develop later. Esophagoscopy in a patient who has not had adequate x-ray examination of the esophagus may eventuate in perforation of a diverticulum.[8]

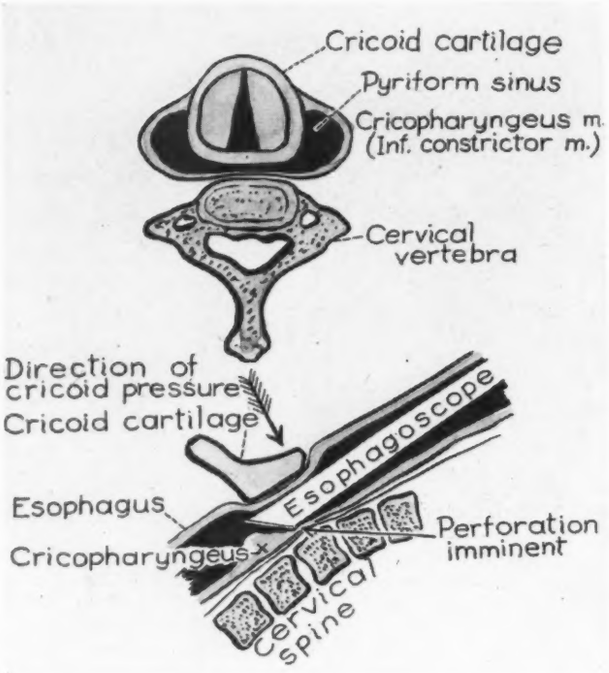

Fig. 2. A diagrammatic cross-section through the pharynx at the level of the cricoid cartilage to illustrate how the cricopharyngeus muscle holds the posterior plate of the cricoid cartilage against the posterior wall of the pharynx and the bodies of the cervical vertebrae. Below, diagrammatic sagittal section illustrating the problem of getting the esophagoscope past the cricopharyngeus muscle.

Following perforation, the esophageal contents escape into the retrovisceral space and inflammation develops. The complaints are pain, and difficulty in swallowing. The signs are air in the tissue, tenderness over the area and rigidity of the cervical spine. X-rays disclose air in the tissues and displacement of the trachea forward. Whereas some of these patients with small perforations will localize their infections and recover, the treatment of choice is drainage of the retrovisceral space as advocated by von Hacker in 1901.[35] This operation, called cervical mediastinotomy, is approached through an incision along the anterior border of the sternocleidomastoid muscle (when the site of the cervical perforation is not definitely localized, the operation should be in the right side of the neck).[8] The sternocleidomastoid, sternohyoid and sternothyroid muscles are exposed and with the carotid sheath, are retracted laterally. When the lateral lobe of the thyroid gland is elevated it may be necessary to ligate branches of the inferior thyroid veins. By blunt dissection, the retrovisceral space behind the esophagus is opened and drained.

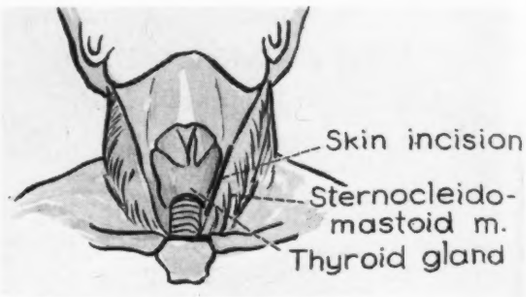

Fig. 3. Cervical mediastinotomy with drainage of the retrovisceral space is the treatment of choice for perforation of the cervical esophagus.

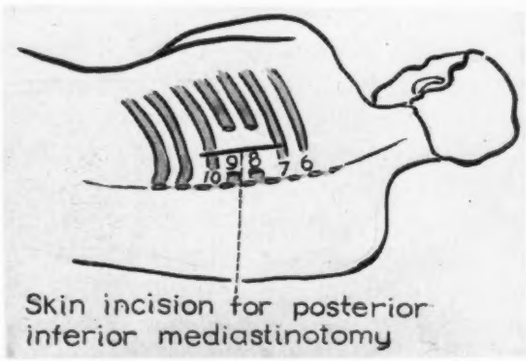

Fig. 4. Posterior mediastinotomy has been used for draining the mediastinum after perforation of the thoracic esophagus. It is probable that transpleural approach will give better results. When there is involvement of the pleural cavity, as there always is in "spontaneous perforation," transpleural approach with suture of the laceration is indicated.

Foreign bodies are more apt to perforate the cervical esophagus than other parts of the esophagus. Here, following proper examination, localization of the foreign body and preparation of the patient, the foreign body must be removed and cervical mediastinotomy performed if inflammation has developed.

Perforation of the thoracic esophagus usually occurs at the points of constriction. These are in the mid-esophageal region where the esophagus is compressed from the left by the arch of the aorta and anteriorly by the crossing of the left main

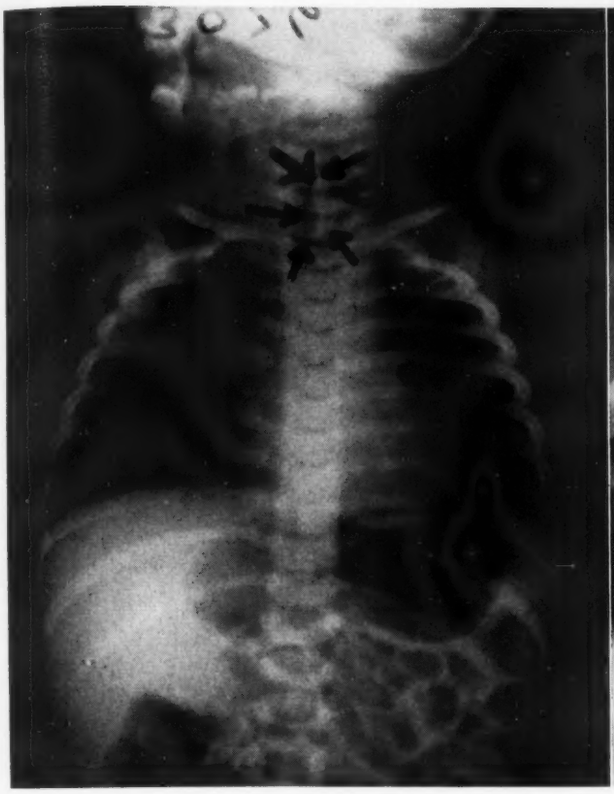

Fig. 5. Initial chest x-ray showing the piece of glass lodged in the cervical esophagus. Glass is partially radiopaque.

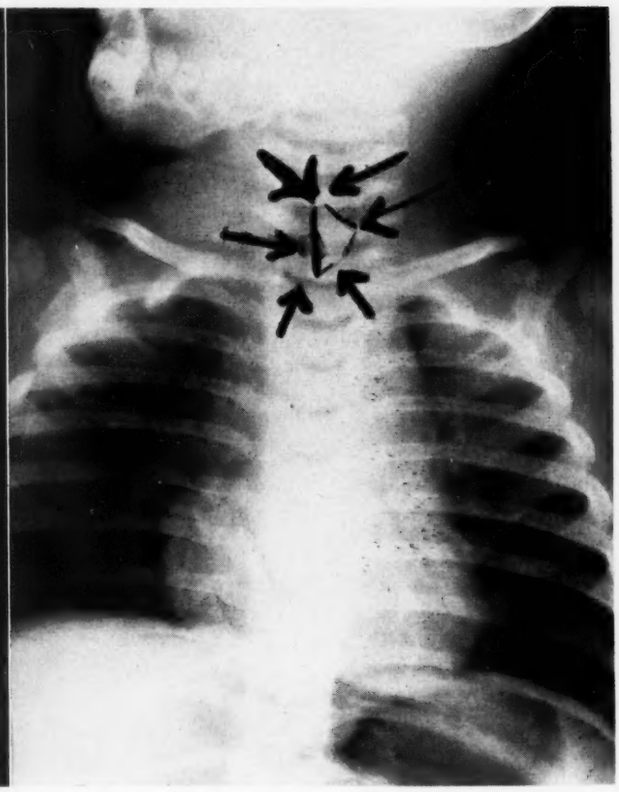

Fig. 6. The piece of glass recovered from stool on the second postoperative day is here superimposed on chest x-ray in Figure 5.

stem bronchus, and just above the diaphragm.

Perforation in the upper and mid-esophagus is usually due to foreign bodies. The supradiaphragmatic portion, besides being the site of the spontaneous perforation, is the place where dilatations for cardiospasm and strictures can readily result in rupture.

Perforation of the upper and mid-esophagus gives rise to mediastinitis and may enter one or both pleural cavities. When the latter occurs, pneumothorax, subcutaneous emphysema and later pleural effusion with emphysema supervenes. The complaints here are pain in the chest, dysphagia, chills, fever, and when the pleural cavity is entered the symptoms are more severe with pain, dyspnea, cyanosis and a shock-like picture. Tension pneumothorax easily develops. When the pleural cavity is entered the chest x-ray is characteristic but when the lesion is confined to the mediastinum, one may see only widening of the mediastinum. Posterior mediastinotomy with retro-pleural drainage has been the operation of choice in treating mediastinitis. However, this approach has certain disadvantages so that transpleural drainage is probably the approach of choice.

Perforation of the lower end of the esophagus is usually due to instrumentation (attempts to dilate cardiospasm or stricture) and to "spontaneous perforation." Perforation at this location is characterized by entering one or both pleural cavities with the resultant complications of pneumo- and hydro-thorax. The complaints are severe pain, usually abdominal and later thoracic, with the rapid development of a shock-like picture. One of us (J.E.S.) has been associated with one such case of "spontaneous perforation" which was operated upon for perforated peptic ulcer; the true lesion, perforation of a peptic ulcer of the lower esophagus, was disclosed at autopsy. The diagnosis is easily made provided one thinks of it. The pneumo-thorax (later becoming a pneumo-hydro-thorax), subcutaneous emphysema, tension pneumothorax and the aspiration of gastric contents from the pleural cavity are characteristic. The diagnostic triad of "spontaneous perforation

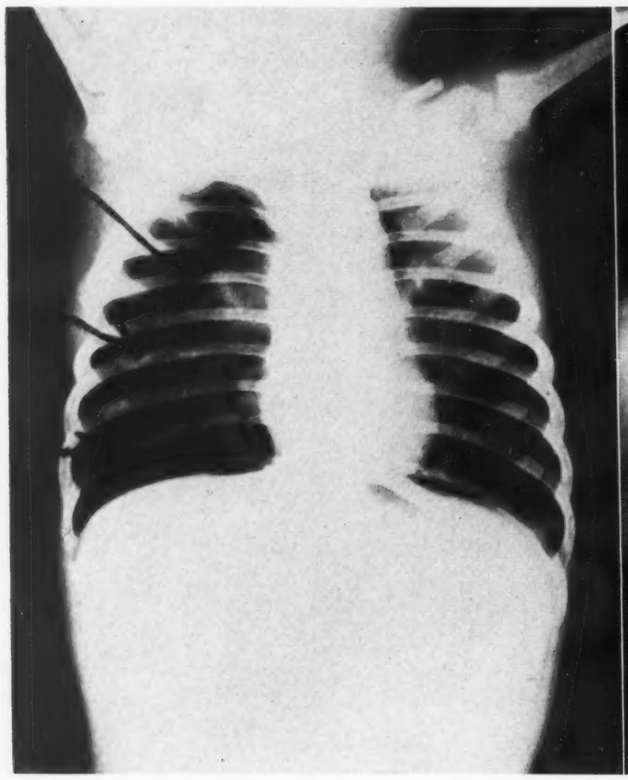

Fig. 7.

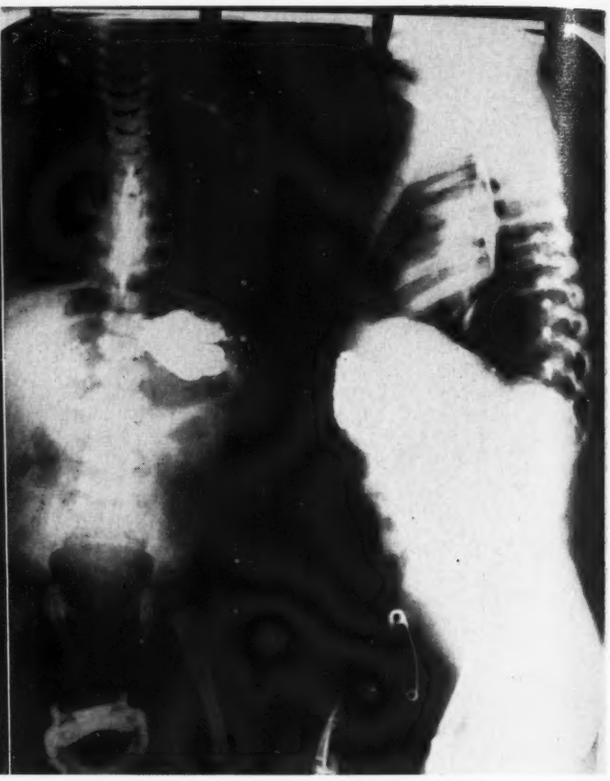

Fig. 8.

Fig. 7. Chest x-ray following esophagoscopy revealed right pneumothorax. The incidence of pleural entry increases as the site of the esophageal perforation moves down; in the cervical esophagus, pleural involvement is unusual; perforation of the lower esophagus practically always involves one or both pleural cavities.

Fig. 8. Oral ingestion of radiopaque material, in this case, does not reveal a laceration of the esophagus even though there has been a direct pleural entry. Pleural effusion would develop rapidly.

of the esophagus"[1] are: (1) rapid respiration; (2) abdominal rigidity, and (3) subcutaneous emphysema.

Such a patient is desperately ill and one may hesitate to operate, but immediate transpleural approach with suture of the laceration and cleansing of the mediastinum and pleural cavity with transpleural closed drainage has given excellent results.[1,2,4,19,20,21,23,30,32,37] It is to be noted that whereas closure by suture with drainage of the mediastinum and pleural cavity is frequently feasible in "spontaneous perforation" occurring in the lower esophagus, perforations in the upper thoracic and cervical esophagus are usually treated by drainage only. The increasing awareness of the profession to the occurrence of "spontaneous perforation" of the esophagus is reflected in the number of papers appearing on the subject.

Case Report, No. 5569

The patient, a ten-months-old white boy, was carried to the emergency room of a hospital Wednesday evening, August 12, 1953. The mother stated that she had seen the baby break a glass ash tray and put a piece of the glass in his mouth, but that she was unable to prevent him from swallowing it. Following this, the baby spit up a little blood and was fretful. The intern on duty had three x-ray films taken and after examining the child told the mother that the baby had not swallowed the glass and to take him home. The infant was very restless that night crying and keeping the family up most of the night. The next day the family doctor was called but he also did not think that the baby had swallowed the glass. Later that day the roentgenologist saw the x-ray film (Figs. 5 and 6) and noted a foreign body in the cervical region. Esophagoscopy was attempted but the foreign body was not recovered. During or shortly thereafter the baby became acutely ill and chest x-ray (Fig. 7) showed right pneumothorax. The infant was then transferred to the Ingham Sanatorium.

Examination revealed an acutely-ill appearing white male infant apparently in respiratory distress. Right pneumothorax was present. Temperature 101 F. rectally; pulse 130, respirations 32 per minute; blood count: RBC, 3.86 million; hemoglobin 11.9 grams (71.4 per cent); WBC 15,300 with 61 per cent polys. The temperature rose to 103 F. rectally. A small amount of radiopaque liquid was given orally and no leak from the esophagus was seen (Fig. 8). Antibiotics were administered.

On August 14, 1953, under ethyl chloride and ether anesthesia, bronchoscopic and esophagoscopic examinations were performed. Bronchoscopy was negative. Esophagoscopy revealed a small defect in the right posterolateral wall of the esophagus just above the level of the aortic arch. Directly following this examination and under endotracheal anesthesia, right thoracotomy was performed. A small amount of thick purulent appearing material was noted in the lower posterior pleural space. Immediately above the root of the lung a laceration in the mediastinal pleura was noted and extensive inflammatory changes were present around this area. The mediastinum was opened and thoroughly debrided and washed out. No definite tear in the esophagus could be demonstrated. The mediastinum was drained retropleurally and closed drainage of the right pleural cavity was instituted. Recovery was uneventful. Drainage was minimal. On the second postoperative day, the infant passed the piece of glass during a normal defecation. One week postoperatively the skin sutures were removed (Fig. 9) and the patient was discharged.

Comment

This case illustrates several typical features of perforation of the esophagus by a foreign body. It should be remembered that parents are occasionally correct in their observations; also that glass is partially radiopaque. The foreign body lodged in the cervical esophagus. Just which component, the foreign body or the esophagoscope, predominated as the etiological agent in the perforation of the esophagus is not known. Direct involvement of the right pleural cavity occurred during esophagoscopy. The foreign body transversed the remainder of the gastrointestinal tract without incident.

Summary

Perforation of the esophagus is discussed and a case is presented. Perforation of the esophagus is a surgical emergency which can be successfully treated.

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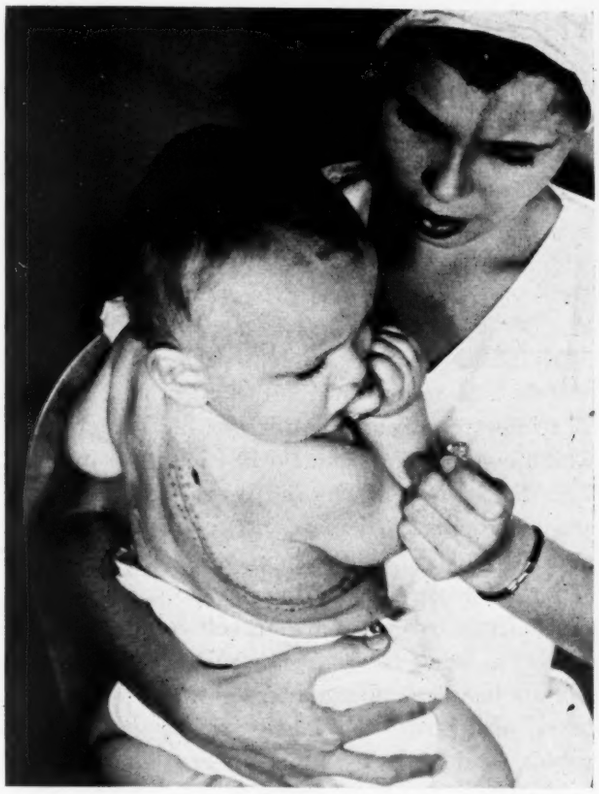

Fig. 9. The patient, seventh day postoperative, showing the thoracotomy wound healed. He is looking at the piece of glass which he had previously swallowed.

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Trichiniasis

Report of Six Cases

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TRICHINOSIS or trichiniasis is an infestation with a round worm, the trichinella spiralis. The infestation is acquired by the ingestion of flesh which contains the encysted larvae of the parasite. The disease is characterized by various local signs and symptoms particularly as regards the muscles and there is generally an associated systemic reaction. The trichinella spiralis has a world-wide distribution, its principal reservoir for human consumption being the pig. However, the trichinella spiralis has been found in rats, mice, bear, dogs, foxes, wild boars, cats and other carnivora. Fish, reptiles and birds have never been found as hosts to the parasite. The United States Public Health Service has estimated through diaphragm studies, that 17 per cent of the population in the United States are infested. This percentage of the population may become ill and exhibit symptoms, of which one-fifth per cent are confined to bed by the disease. All hosts are known to harbor both the larval and adult forms.

Man becomes infested by eating raw or insufficiently cooked porcine products which contain the encysted larvae. This disease has occurred after the ingestion of bear meat and in those countries where dog meat is eaten. Rats are a factor in the transmission of the disease as hogs will consume infected rats, in this manner being themselves infested, and thereby later becoming the source of transmission to man. When man eats pork products containing viable encysted larvae, the cyst capsule is digested in the stomach and the larvae are set free. These larvae attach themselves to the walls of the stomach, jejunum and duodenum. In this area they develop into adult worms in two or three days. The male is about 1.5 mm. and the female 3 mm. in length. The males die after impregnation of the female, but as a rule cannot be found in the stools. The fertilized females penetrate the mucosa of the bowel and about eight days after impregnation fully formed embryos are discharged. These embryos are fully and completely formed when born, being very small (about 0.1 mm. in length) and can easily penetrate the lymphatics and the blood vessels. They are thus readily disseminated throughout the body by way of the portal blood stream, the thoracic duct, subclavian vein and through the systemic circulation.

Those embryos which reach striated muscles survive, the common muscle sites being the diaphragm, tongue, ocular muscles, skeletal muscles, with the deltoids and intercostals preferred. However, the embryos have been found in the heart muscle, spinal fluid, bone marrow and milk of nursing mothers. In the striated muscles the embryos penetrate the muscle fibers and grow to a length of 1 mm. Here they may become coiled and encysted and can remain viable for as long as twenty years. This encapsulation begins at about the thirty-fifth day. The cycle is said to be completed when this muscle food is ingested and the larvae are again liberated.

Many studies have been made to attempt to determine the degree of heat needed to kill the encysted larvae in pork. One hundred and forty degrees Fahrenheit is usually stated to be sufficient. The trichinella spiralis may also be killed by refrigeration at zero degrees for not less than 20 days. This, however, is not practical. The incidence of infestation in corn fed hogs is 0.91 per cent, while garbage fed hogs have a higher rate, it being 4.41 per cent. Thus it can be noted that smoking, pickling or insufficient cooking will not kill the larvae, this making an observation of utmost importance.

Pathology

The pathology of trichinosis is usually based upon the life cycle of the parasite. The microscopic lesions noted in the intestine chiefly, but seen to a lesser extent in the stomach, is that of congestion, small areas of hemorrhage in the mucosa, and at times small ulcers. The adjacent lymph nodes are swollen, soft and congested. The liver, kidneys and at times heart show parenchymatous and fatty changes. The spleen at times becomes enlarged. Hemorrhages may occur beneath the serous membranes. The lungs become congested and pneumonia does occur. Grossly, the skeletal muscles may show small grayish translucent areas which are en-

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capsulated larvae. This occurs after the fifth week of the illness. In hogs, with the disease well encapsulated, the gross lesions can be more easily seen.

Histology

The histologic picture is that of cloudy swelling of the various organs, congestion of the spleen due to the toxemia produced by the larvae, and the tissue reactions produced directly by the larvae themselves. During the wandering stage the destructive action may be seen in the brain, lungs, pancreas, spleen, heart muscles and intestines. There is local inflammation and necrosis with infiltration by eosinophiles, polymorphonuclear cells, lymphocytes and endothelial cells. In the muscles the larvae cause necrosis of the sarcolemma with a cellular reaction as occurs in other organs. Later this inflammatory reaction undergoes fibrosis which forms the capsule of the encysted parasite, and as time goes on this undergoes calcification. Beginning about six days after infestation the toxic symptoms of the disease may be due to poisons produced by the larvae and perhaps poison set free by tissue destruction as well as an anaphylactic reaction from destroyed larvae.

Symptomatology

The symptoms appear to depend upon the severity or degree of infestation. If few trichinella are present, the symptoms may be mild or there may be practically none at all. It is stated that if there are 500 to 1,000 larvae per gm. of muscle, the symptoms are severe; if over 1,000 per gm. of muscle the case is a critical one. Thus the disease occurs in all degrees of severity. Where a number of persons in one family are involved, it is not unusual to see some members desperately ill and even die, while others are ambulant and almost symptom free. Fortunately, many cases are mild.

The disease may be roughly divided into three stages as follows: (1) invasion or intestinal stage; (2) period of muscular dissemination; and (3) period of encystment.

The stage of invasion or onset may last for seven to ten days. The onset is usually abrupt and there is nausea, watery diarrhea, evident fatigue, fever, headache, and vague abdominal pains. Sweating at the onset and throughout the disease often occurs as well as vomiting, general body pains, weakness and chilly sensations. Occasionally constipation occurs. The early picture is not unlike influenza. These earlier symptoms correspond to the period when the ingested and encapsulated larvae are developing and attaching themselves to the mucosa and reaching the adult stage. At this time the worms may be found in the blood and stools. Slight eosinophilia may be present and hemorrhagic areas noted under the finger nails (splinter nails). The toe nails are never involved. At this time there may be decreased elasticity of the muscles, the so-called "lahmigkit" which occurs before the muscular invasion. The fever varies in intensity from 100 degrees to 105 degrees F. and is of the remittent type being higher at night. It may last as long as six weeks and usually terminates by lysis.

The period of dissemination or muscular invasion has its onset about the eighth or tenth day. Penetration of the muscles occurs and with this there is myositis with local muscle tenderness and pains. Commonly at this time the clue to the diagnosis as based upon physical findings may make itself evident, namely, the presence of periorbital swelling. Thus at this stage of the illness two conditions occur which should always arouse the suspicion of the clinician as to the possibility of trichinosis, namely, periorbital swelling and muscle tenderness.

The muscle tenderness and pain is readily elicited by squeezing the muscles preferably nearer to the tendinous insertions as here the trichinae are most numerous. In some cases the muscle pain causes much suffering and disability, producing general body stiffness and weakness. The respiratory muscles may become involved causing breathing difficulties and even death. Difficulty in mastication and speech also occur. In some cases there is complete absence of muscle pain. The eyes often show much involvement. There is often periorbital edema which may be very slight, or there may be marked edema and swelling of the eye lids and periorbital tissues with chemosis of the sclera, and severe conjunctivitis with hemorrhage into the subconjunctival tissues. In one of our cases, the corneae were almost covered by the great swelling of the sclerae. Ocular movements may become painful and fundal hemorrhages have been described. The eye symptoms usually begin about 7 to 10 days after the onset of the disease and persist for about one week.

Various skin lesions occur. Roseola, maculo papular in type, like those seen in typhoid fever

may occur upon the abdomen. Also there may be a generalized erythematous rash not unlike that seen in Brill's Disease (mild typhus). Herpes Labialis occurs, and often severe pruritus as well as urticaria may be noted. Chest complications are not uncommon and there may be a slight bronchitis or severe bronchopneumonia. The latter occurs quite often in severe infestations and at times causes death. Neurological complications often occur due to central nervous system involvement. Severe and constant headaches, vertigo and marked rigidity are frequently seen. Hemiplegia has also been reported with exaggerated knee reflexes and positive Babinski sign. In these cases trichinella have been found in the spinal fluid.

During the height of the illness, if the case is a severe one, the patient may appear flushed, the eyes are injected, extreme apathy and drowsiness is noted but as a rule the patients can be easily aroused. The heart action is rapid, pulse thin and fast and the blood pressure is low. The tongue is usually heavily coated, pulmonary signs are present with rapid respirations and cough. Myocardial involvement is common and myocardial failure and general weakness may cause death. The abdomen is often distended and tender on palpation. Extreme prostration is common and great weight loss is the rule; if the case is mild, the symptoms are proportionately less severe. Trichinae as a rule are not found in the myocardium but occasionally have been demonstrated. Electrocardiographic studies have shown evidence of myocardial degeneration. At this period in the disease, the eosinophile count is often as high as 30 per cent to 50 per cent and severe anemia may be present later.

The period of encystment is the stage of convalescence. The fever gradually declines, the patient brightens mentally, the appetite improves, muscle pains cease, and the strength starts to return. The convalescence is extremely slow in a severe case. The entire illness may last from 10 days to 6 and 8 weeks.

Differential Diagnosis

In an illness with such a varied type of onset and many complaints and symptoms as well as physical signs, many disease entities will enter into the differential diagnosis. Such conditions as the following must be differentiated: influenza, so-called intestinal influenza, sinusitis, ocular infections, rheumatic fever, typhoid-paratyphoid fever, salmonella infections, meningitis, encephalitis, poliomyelitis, periarteritis nodosum, dermatomyositis, pneumonia, undulant fever, Brill's Disease, etc.

Special Tests and Laboratory Examinations

1. *Blood counts.*—Leukocytosis of 12,000 to 30,000 occurs with eosinophilia of 10 per cent to 50 per cent, and at times as high as 80 per cent. The height of the eosinophilia occurs in the third or fourth week and usually begins about 10 to 14 days after the onset. The degree of eosinophilia is not dependent upon the severity of the disease. Mild cases may have high eosinophilia and there may be considerable variation from day to day. Eosinophilia in this disease was first noted by Brown at Johns Hopkins in 1897. A sudden drop in eosinophilia may be due to a secondary infection or if no bacterial infection is present it may be a bad prognostic omen. Eosinophilia is also seen in Loefler's pneumonia, eosinophilic leukemia and other blood dyscrasias, asthma and allergic states, Hodgkin's Disease, other parasitic infestations, periarteritis nodosum, and certain skin diseases.

2. *Intracutaneous Skin Tests.*—The antigen used is a saline extract of the larvae of trichinella spiralis free from the tissue of the host in which the parasite developed. The test, which is based on a sensitivity to trichina substances that develops in the skin, may be applied to any stage in the infection but usually no reaction is observed before the sixteenth day after the onset of the illness. The tests consist of an intradermal injection of .1 c.c. of the antigen in the skin of the forearm. A control consisting of saline or Cocas solution is also injected.

The positive skin reaction is of the "immediate" type. It is characterized by the development within 20 minutes of an elevated wheal or edematous blanched area, from 8 mm. to 15 mm. in diameter from which pseudopods may or may not radiate out into an encircling zone of redness from 20 mm. to 50 mm. wide. The flare reaches its height within one half hour and rapidly subsides. It is essential to have a control so as to eliminate false reactions. The positive skin reaction may persist for several years.

3. *Blood precipitins.*—Positive after 30 days, the material is hard to obtain.

4. *Complement fixation test.*—Positive after 30 days. The State of Michigan accepts the blood and sends it to Georgia for the tests.

5. *Blood studies for finding of the parasite.*—10 c.c. of blood is laked with 3 per cent acetic acid and then centrifuged. The sediment occasionally will show the trichinella. Spinal fluid; Trichinella spiralae have been found in the spinal fluid.

6. *Biopsy.*—Removal of muscle preferably near the tendinous insertions. One may find the encysted trichinella or a local reaction in the muscles.

Therapy

At the onset, thorough catharsis is essential in order to rid the intestinal tract of as many parasites as possible. Ample foods are given and temperature sponges and alcohol rubs used freely. Bed rest is important because of possible cardiac involvement. Supportive therapy by administration of intravenous glucose solutions and transfusions may be required. Many drugs have been used—all of which including convalescent serum by Saltzer having proven ineffectual. Sulfa drugs and antibiotics have been used but have produced no direct effect upon the parasites. They may, however, have some beneficial effect upon some of the complications such as bronchitis or pneumonia.

Recently Davis and Moss in an article in the November, 1951, issue of the *American Medicine* have described a patient with definite trichiniasis. Their patient was extremely ill and was given a five-day trial of Hetrazan in a dosage of 0.3 to 0.6 gm. per day by mouth. This therapy was not effectual. The patient's condition deteriorated, so ACTH was started on the 10th hospital day with the dose of 200 mg. daily, given as 50 mg. every six hours. At times 100 mg. was given in the 24-hour periods. This was continued for over 17 days. Dramatic subjective improvement is mentioned with a fall of temperature and increased appetite. When the ACTH was discontinued some fever returned for a few days.

Hetrazan has been used with some success according to Davis and Moss, against the migratory filarial forms of Wiecheriria Banscroft, Loa Loa and Onchoceria in both experimental infections and in patients. They quote Heuit in stating that the number of adult trichinae in the intestines of treated rats was reduced as compared to control untreated rats. Larval forms were also less. Hetrazan is diethyl carbamaine, and is made by Lederle, the dose being 2 mg. per kilo, t.i.d.

In the treated case Hetrazan was used only for three days so that its value could not be ascertained. An eosinophile drop occurred with the use of ACTH. Muscle invasion was unaffected by ACTH, but the diffuse myositis was altered. There was no evidence of larvicidal effect. The benefit of ACTH was said to be a result of its nonspecific effects. ACTH and cortisone may be agents which are capable of modifying the body's reaction to the invasion of the muscle by the larvae or their products.

Case Reports

Case 1.—O. A., aged 62 years. His occupation was grain and seed dealer. He was admitted to Harper Hospital November 18, 1949, and discharged January 11, 1950.

About two weeks prior to the onset of the illness this man ate smoked ham which was uncooked. He was admitted to the hospital with fever and chilly sensations. The fever rose gradually until it reached 102 degrees. Drenching sweats and diarrhea of seven or eight watery stools daily for about ten days were present. The appetite was not good and there was a weight loss of 10 pounds in 2 weeks. He was thought to have a virus infection since at this time there was considerable so-called "intestinal" flu around the city. One year prior he had had a coronary occlusion from which he made a good recovery. At the time of admission the only physical findings of any importance were fine rales at the left base posteriorly and scattered fine rales over the right upper chest. The initial blood count disclosed white blood cells, 8,600; polymorphonuclear cells, 65 per cent; lymphocytes, 24 per cent; eosinophiles, 4 per cent; Kahn negative. Agglutination tests for typhoid, paratyphoid, brucella abortus, melitensis and dysentery groups were all negative. A blood smear for malarian parasites was negative. The stools were negative for ova and parasites.

On November 23, five days after admission, periorbital swelling and edema were first noted. This became very severe in a few days and even involved the sclera and conjunctiva almost to the extent of excluding the vision. At this time the white blood cells were 12,700 with 12 per cent eosinophiles. Muscle pains were not present at this time or any time during the course of the illness. The heart action was regular and there were no murmurs. The pulse was rapid and soft. The blood pressure was low and the electrocardiograph showed possible bundle branch block. The knee jerks could not be obtained. There was slight neck rigidity and a positive Kernig. On December 6 pneumonia involving the right and middle lobes was noted. The patient was semicomatose and ran a continuous and septic type of fever. He looked like a patient in the third week of severe typhoid fever. His fever continued for about 50 days from the onset of his illness and finally fell by

lysis on December 28. He was seen by Dr. Edward Spalding who concurred in the diagnosis, and reported the cardiac status to be good. He also gave a good prognosis which proved to be correct.

A skin test for trichiniasis was made and was negative. The highest eosinophile count was 33 per cent on November 28. Muscle biopsy made December 12.

Therapy consisted of the following drugs: Sulfadiazine, Streptomycin, penicillin, Chloramycetin and colloidal sulphur. None appeared to have any specific effect. Supportive therapy with high caloric diet, fluid supplements, continuous special nursing care, and oxygen contrived to assure recovery for this critically ill patient.

Case 2.—Mrs. O. A. was admitted to Harper Hospital December 2, 1949, and discharged January 9, 1950. This patient was not very ill. She was admitted with chilly sensations only. There were no gastric symptoms and very little fever. She did have periorbital swelling which was not severe. The white blood count was 12,950 and the eosinophiles were 32 per cent. On December 4, 1949, the skin test for trichinae was definitely positive. At no time during the illness was muscle pain or muscle tenderness noted. Muscle biopsy was made.

Therapy consisted of Chloramycetin and calcium lactate in addition to routine nursing care. She made an uneventful recovery.

Case 3.—G. A. was 24 years of age and was admitted to Harper Hospital November 25, 1949, and discharged January 15, 1949. The illness began on November 20 with fever, cough, fatigue and chilly sensations. Two days later periorbital edema and evident conjunctivitis was noted. His fever rose to 102.8 degrees and he became lethargic and toxic. Macules were present upon the abdomen which had the appearance of "typhoid spots." There was no muscle pain or muscle tenderness at any time. The white blood count was 9,600 and the eosinophiles varied from 17 per cent to 38 per cent. Study of the blood at the onset was positive for trichinae in Toronto. The skin test was slightly positive. Electrocardiogram was normal. Stools were negative for trichinae. Muscle biopsy was done.

Case 4.—Mrs. G. A. was admitted to Harper Hospital December 4, 1950, and was discharged December 30, 1950. This was a mild case, without fever. There was moderate periorbital edema and diarrhea for three days with pains in the calf muscles. The white blood count was 13,100 with eosinophiles 11 per cent. Skin test was negative. Muscle biopsy done.

Case 5.—M. A., aged 36 years, was admitted to Harper Hospital November 24, 1949, and discharged December 18, 1949. The first symptom noted was swelling of the eyelids and conjunctivitis. Fever was present at the onset and persisted until December 11. There were no muscle pains or tenderness. Blood studies for trichinae were negative. The white blood count was 20,000 and the highest eosinophile count was 38 per cent. Muscle biopsy was done. Therapy consisted of Chloramycetin and calcium gluconate in addition to routine nursing care.

Case 6.—S. F, aged 29 years, occupation, meat packer, and sausage manufacturer, was admitted to Harper Hospital January 5, 1950, and discharged January 15, 1950. He became ill on January 1, 1950, with malaise, fever, severe frontal headache. The fever varied from 100 to 102 degrees prior to hospital admission on January 5. Upon hospital admission, a maculo papular rash such as seen in Brill's disease was present upon the chest, abdomen, arms and feet. The rash was not pruritic. The patient had received penicillin. However, the rash did not appear to be a penicillin rash and its onset was too early. There had been pains in the forearms, knees and calf muscles ten days prior to the onset of the illness. This, however, was of frequent occurrence with this man especially during inclement weather. The general physical examination was negative and there was no periorbital edema. The white blood count was 7,500 and the highest eosinophile count was 39 per cent. Agglutination for Proteus x-19 was negative. Stools were negative for parasites. Skin test was negative for trichinae. Fever varied from 99 to 102 degrees. Muscle biopsy was done. Blood cultures were negative. The rash persisted for ten days.

Therapy included Sulfadiazine and Aureomycin.

Of the six patients, two had positive skin tests, four had negative skin tests. Two had muscle pains and four had no muscle pains. In none of the biopsies were encysted trichinae found, although definite eosinophilic infiltration was noted in all of the biopsy specimens. The unusual finding was the complete lack of muscle pains and local tenderness in four of the cases including the most severe one. There was minimal muscle pain in the two milder cases. All of the patients made a good recovery.

For a complete study of trichiniasis the reader is referred to the excellent monograph by Doctor S. Gould.

Cancer morbidity records will, when properly analyzed, show the need for and progress of a cancer control program, give to the medical profession information that will enable them to improve the end results of treatment, bring added benefits to those individuals afflicted with cancer, and assist the community in developing the most effective control program possible with the money available.

The importance of follow-up of cancer patients cannot be over-rated, for it is only by such means that the early detection of recurrences is possible.

* * *

Statistics regarding the incidence, prevalence and survival of cancer cases are of value in planning lay educational programs.

Trichophyton Tonsurans Ringworm

By Eugene A. Hand, M.D.
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and
Lucille K. Georg, Ph.D.
Chamblee, Georgia

TRICHOPHYTON TONSURANS infections of the scalp, glabrous skin, and nails have been common in Puerto Rico and Mexico for many years. Until the past few years the disease has been thought to be rare in most sections of the United States. A number of cases had been reported from several of the eastern port cities, particularly New York City, but the percentage of tinea capitis cases caused by *T. tonsurans* was never high, and the infections were largely confined to individuals immigrated from Puerto Rico.[1] However, numerous cases have recently been presented before the New York Dermatological Society meetings. Also in the past several years, relatively large numbers of isolations have been reported from patients seen in the Southwestern States, particularly Texas, and southern California[2,3,4] and the number of cases has been increasing. In some areas 68 per cent of patients with tinea capitis are infected with *T. tonsurans*. Of these, the great majority are Latin-Americans who have immigrated from Mexico. The infections have spread among the Negro and Anglo-American population, and present an important public health problem.

It is now apparent that the disease is spreading to many areas of the United States. Scattered cases have been reported from at least thirteen different states[1] and from Canada. The present report of eighteen cases from northeastern Michigan indicates that endemic areas may develop in any section of the country where Mexican itinerant workers are employed in large numbers, and where a Latin-American population has become established.

Trichophyton tonsurans cases in Northeastern Michigan.

Slaughter and Cawley[5] reported the first case of *T. tonsurans* ringworm in Michigan in 1946. This was a four-year-old white girl with a circinate lesion on the knee, from a farm in Washtenaw County. The first case the authors have observed

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in the Saginaw area was a white farmer boy, aged eight, from Tuscola County, seen August 9, 1951 with a Wood's negative scaly eruption and with patchy alopecia on the occiput. There was a history of contact with a child of Mexican origin who had a scalp eruption. His father, seen simultaneously, had a lupus erythematosus-like eruption on the temples and forehead. Only the knowledge of his son's infection led one of the authors to do scrapings and cultures resulting in a diagnosis. The same was true of the boy's mother who had a herpetic lesion on the forearm. *T. tonsurans* was isolated from the child, the father, and the mother. This family was presented before the Detroit Dermatological Society (October 10, 1951). In the discussion, Dr. R. H. Grekin mentioned one case with a positive culture from Detroit. The first case from the city of Saginaw was seen late in 1951. Two Negro children also were so diagnosed in 1952. One Anglo-American child and ten Negro children, including one 18-year-old male, have been diagnosed as having *T. tonsurans* infection so far in 1953. Numerous other cases not recorded in this series have been seen in the Saginaw free clinics.

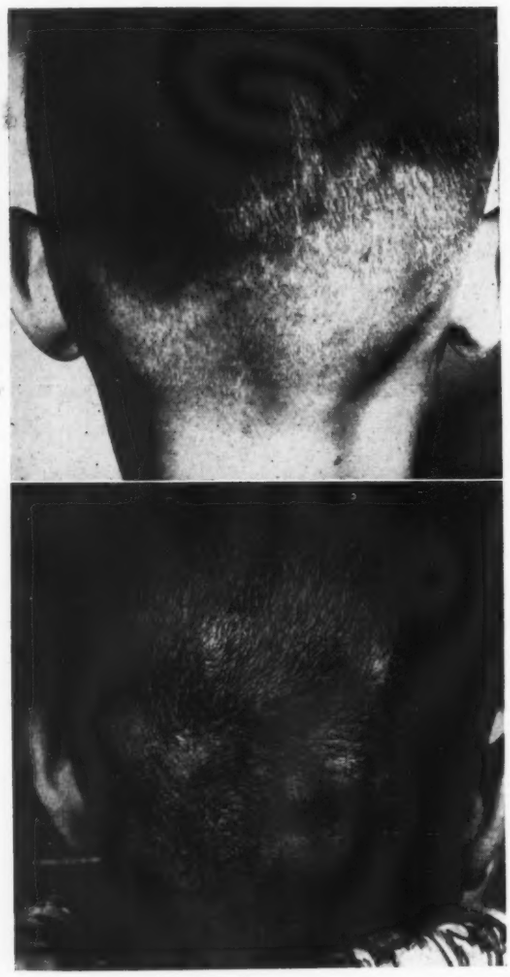

Fig. 1. *Case 1.*—A typical superficial type lesion showing scaling of the scalp and irregularly defined areas of baldness.

Fig. 2. *Case 16.*—Patchy alopecia and beginning suppurative type reaction.

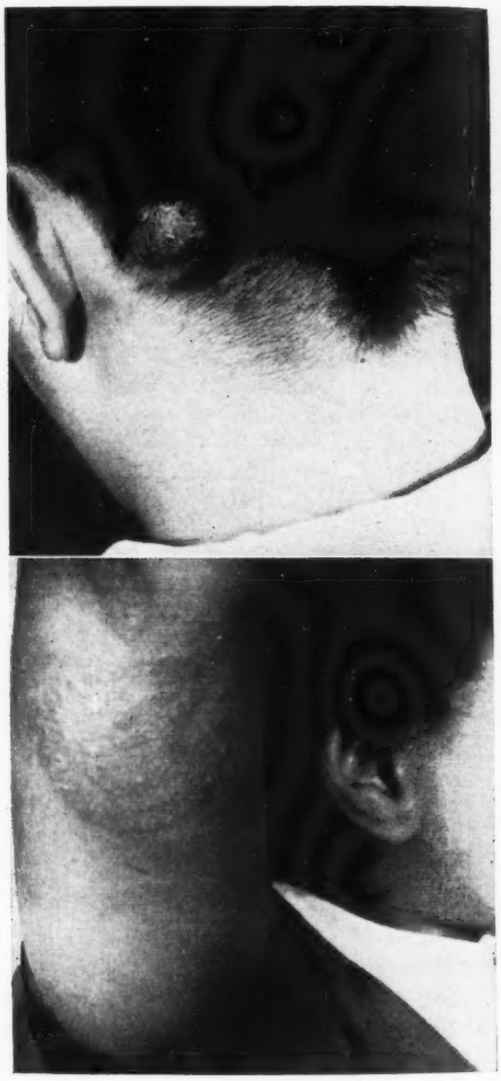

Fig. 3. *Case 9.*—A well-defined kerion.

Fig. 4. *Case 5.*—Agminate folliculitis.

It would seem that Mexican itinerant farm and orchard workers have carried this disease into rural Michigan. The Mexican and Latin-American foundry workers have brought it to Michigan cities. Here this infection is spreading to Negroes, many of whom live in crowded unhygienic conditions in the same districts as the Latin-Americans.

From these sources a few native Michigan, Anglo-American children and adults have been infected. *T. tonsurans* is now endemic in the Saginaw first ward, and may become epidemic.

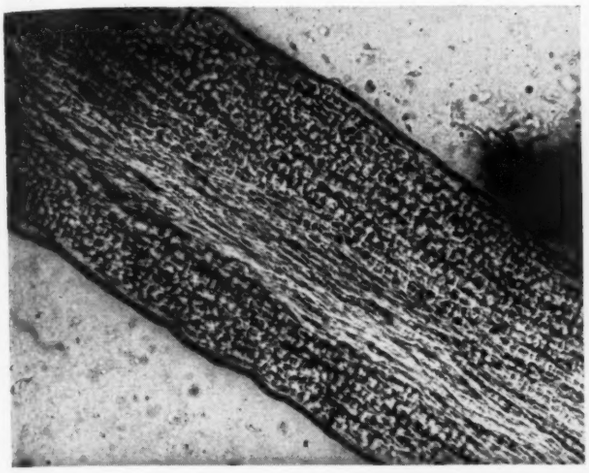

Fig. 5. Hair showing endothrix invasion typical of *T. tonsurans* infection. Note chains of large spores in interior of hair only.

Clinical Characteristics

All the clinical lesions that represent the human body's response to fungus infection in the epidermis, hair, hair follicles, and nails can occur with *T. tonsurans* infections.

The scalp lesions in children and adults are often irregularly defined, scaly patches which can easily be confused with dandruff or even psoriasis. Severe itching is frequently present. Case four illustrates this minimal-type lesion. This was a white, 6-year-old farm girl from Huron County who was first seen in May, 1952, with what appeared to be seborrheic dermatitis sicca of the scalp. The Wood's light examination was negative on numerous occasions, and only the mother's insistence on culture led to the correct diagnosis.

In some cases loss of hair is evident, and stumps of broken off hairs may be found by careful searching. When loss of hair becomes extensive, irregularly defined areas of baldness interspersed with normal hairs may be seen. In such cases where scaling and loss of hair constitute the only tissue reactions, the disease tends to be chronic in nature and is extremely difficult to cure. Figure 1 illustrates such a case.

The development of erythema, suppuration, and kerion is rare in both children and adults, though perhaps more common in the former. Kerion in this series has been more common than is usually seen in *T. tonsurans* infections. Such a tissue reaction is to be desired, as in these cases spontaneous cure usually results. Figure 2 illustrates an early suppurative reaction; Figure 3 shows a kerion.

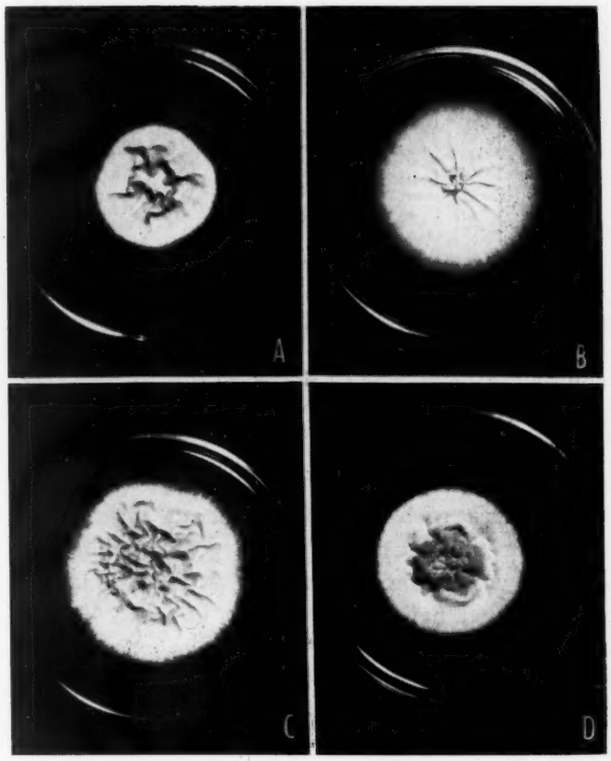

Fig. 6. Colony variants of *T. tonsurans* on Sabouraud's dextrose agar: (A) Variety crateriforme; (B) variety sulfureum; (C) variety cerebriforme; (D) variety acuminatum.

Lesions of the nails and glabrous skin are similar to those produced by the other trichophytons. They often are associated with scalp lesions and this often aids in the diagnosis. The lupus erythematosus-like lesions, as seen with *T. rubrum* infections, are common with *T. tonsurans* infections also. Figure 4 shows a lesion of the glabrous skin.

Wood's Light Examination

For all practical purposes the Wood's light is negative in *T. tonsurans* infections of the scalp. This is most unfortunate and is the chief reason why the diagnosis of this disease is so often missed unless one's index of suspicion is high.

Microscopic Examination

Direct examination with KOH preparations of the hair stumps removed with a fine forcep or point of a scalpel reveals typical endothrix spores arranged in chains (Fig. 5). This arrangement

TABLE I. SUMMARY OF TRICHOPHYTON TONSURANS CASES

Case No.	Age	Sex	Race	Location Lesion	Duration	Type of Lesion	Wood's Light	Microscopic Exam.	Culture	Home Address
1	8	M	W	Occiput	4 Mo.	Scale with patchy alopecia	–	+*	+**	Caro, R.F.D.
2	54	M	W	Face	1 Mo.	L. E. like	–	+	+	Caro, R.F.D.
3	42	F	W	Arm	1 Wk.	Herpetic	–	+	+	Caro, R.F.D.
4	6	F	W	Scalp, trunk	1 Yr.	Scaly circinate	–	–	+	Cass City, R.F.D.
5	10	F	C	Arm	1 Wk.	Agminate	–	+	+	Saginaw
6	8	M	C	Scalp	1 Mo.	Patchy alopecia	–	+	+	Saginaw
7	9	M	C	Occiput	1 Mo.	Kerion	–	+	+	Saginaw
8	4	F	C	Face	1 Wk.	Circinate	–	+	+	Saginaw
9	14	M	W	Occiput	2 Wk.	Kerion	–	–	+	Saginaw
10	4	F	C	Scalp	?	Patchy alopecia	–	Not done	+	Saginaw
11	5	F	C	Scalp	1 Mo.	Patchy alopecia	–	+	+	Saginaw
12	7	M	C	Scalp	4 Mo.	Kerion	–	+	+	Saginaw
13	1	M	C	Scalp	4 Mo.	Impetigo	–	–	+	Saginaw
14	6	M	C	Scalp	2 Wk.	Scaly	–	+	+	Saginaw
15	5	M	C	Scalp	2 Wk.	Scaly	–	Not done	+	Saginaw
16	8	M	C	Scalp	3 Mo.	Patchy alopecia	–	+	+	Saginaw
17	16	M	C	Scalp	1 Mo.	Circinate	–	+	+	Saginaw
18	6	F	W	Scalp, Trunk	3 Mo.	Circinate	–	+	+	Sebewaing

*Microscopic exam. +: Typical endothrix hairs observed.
**Culture +: Typical culture Trichophyton tonsurans recovered.

causes the hairs to be thickened and to break off at the surface. One of the authors (E.A.H.) found this search for and removal of the hair stumps to be very tedious. However, scraping the involved area with the edge of a glass slide and culturing the scrapings gave a positive diagnosis in many cases. The scales from glabrous skin lesions and infected nails reveal fungus elements similar to those seen in other trichophyton infections.

Culture

This organism can be grown with ease on Sabouraud's dextrose agar from infected hairs, scales, or nail scrapings. The culture grows at room temperature in five to seven days and rapidly becomes heaped and folded in various patterns which give a characteristic picture. The surface is usually finely powdery with a range of pigment from white to tan, or shades of rose, violet, or yellow. The fungus is identified on the basis of both the macroscopic and microscopic appearance of the culture. The clinical picture, prognosis, and treatment is the same for all morphologic forms of *T. tonsurans* known as varieties: craterforme, sulfureum, accuminatum, cerebriforme, et cetera. Figure 6 illustrates the common morphologic variants of *T. tonsurans).*

Treatment

T. tonsurans infection of the scalp does not tend to clear at puberty as does *Microsporum audouini* infection. The infection is seen in both children and adults. Temporary x-ray epilation is probably the best treatment, but even here a great deal of after-treatment is necessary to eliminate the infection before the hair regrows.

T. tonsurans infection of the glabrous skin not complicated by scalp involvement responds to fungicidal preparations about as well as that due to the downy type of *T. mentagrophytes.*

T. tonsurans infection of the nails responds poorly to treatment as do all fungus infections of the nails.

Adequate sterilization of barbers' equipment, particularly scissors and clippers, would appear to be an important step in controlling spread of ringworm of the scalp of all types. One of the authors (E.A.H.) is of the opinion that thorough shampoos after hair cuts may help to prevent new cases, and suggests that daily shampoos in sibling contacts may aid in preventing spread in families.

Collodion with or without fungicidal additions painted on the scalp or glabrous lesions has been helpful in cutting down the spread of infection on the individual and also to others.

Conclusions

1. The *Trichophyton tonsurans* organism has been introduced into Michigan by way of farm and foundry workers of Mexican origin. From them it has spread to Negroes and Anglo-Americans, where it involves both the scalp and glabrous skin.

2. *T. tonsurans* ringworm is an important public health problem for the following reasons:

(a) It is difficult to diagnose because the hairs do not fluoresce under the Wood's lamp, and also minimal scalp lesions may be easily confused with dandruff.

(b) It does not tend to clear at puberty and is seen in adults as well as children.

(c) It is refractory to treatment as there is little tendency to inflammatory reaction.

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Jimson Weed Poisoning

A Report of Two Cases

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EVERY year 12,000 to 13,000 children in the United States are killed by accidents; 40,000 to 50,000 are permanently injured; and at least 1,000,000 seek medical care because of accidents.[2] One of the common accidents is the injestion of toxic foreign material including plants and plant seeds. This article is a presentation of two cases of poisoning in siblings by Datura stramonium, otherwise known as Jimson weed, Jamestown weed, Thorn apple, Devil's apple, or intimately as "stinkweed," which though not common is far from rare. This form of poisoning is often misdiagnosed with diagnoses varying from acute schizophrenia to alcoholic delirium.[5] The reason for misdiagnosis is probably due to the lack of familiarity with this entity because of the scarcity of publications concerning it. It is for this reason that the following cases are presented.

Case Reports

Case 1.—P. B., aged three years, was admitted to the Edward W. Sparrow Hospital on August 5, 1954, for observation because of "strange behavior" of about two hours duration. The present illness began when the patient awoke from his afternoon nap, and according to the mother acted very excitable, and did not seem to recognize his parents. The past history was negative. The day of admission was not unusual. The family had had breakfast and an early lunch at 11:00 a.m. The children had played in the yard until 1:30 when the patient came into the house and asked to take his nap which was not an unusual event for the child. Following the nap he awoke in the condition stated above.

Physical examination revealed a well-developed, well-nourished, white boy of stated age sitting in bed, not aware of his surroundings, having active hallucinations, and picking "nothings" out of the air. There was pronounced ataxia of the extremities and a mild trunkal ataxia. The child was moderately irritable. The skin was markedly flushed over the entire body, but the temperature was only 98.4 degrees rectally. The pupils were maximally dilated and did not respond to light. The mucous membranes were dry and covered by thick layers of dry secretions. The pulse was 168 and irregular. Over the precordium ectopic beats were heard. The remainder of the physical examination was essentially normal.

Laboratory findings were all within normal limits.

Case 2.—T.B., aged five, sister of the above, was admitted at the same time for "strange actions and staggering." The history here was the same except that she lay down in the yard to take a nap; awoke about 3:00 p.m. and cried, felt sick, staggered and acted strangely.

Physical examination revealed a well-developed, well-nourished child of stated age lying quietly in bed, with occasional clonic movements of the extremities. She was oriented but did not appear interested in her surroundings. The skin was markedly flushed. The pupils were maximally dilated with minimal reaction to light. The mouth and lips were covered with dry secretions. The pulse was 108 and regular. The remainder of the physical examination was essentially normal.

Laboratory examinations were all within normal limits.

The parents were questioned carefully about the possibility of drug ingestion but none could be obtained. They were asked to look in the yard for any weeds, seeds or fruit which the children could have eaten.

Both the children were treated with seconal rectally, and intravenous fluids of glucose in water, and glucose in lactate Ringers solution.

Shortly after admission the girl vomited a small amount of fluid containing many seeds, which were sent to Dr. W. B. Drew of the Michigan State College Botany Department, along with some empty pods and leaves the parents had found in the yard and brought in the following morning. Attempts to lavage the boy were unproductive. Dr. Drew's report was as follows: "Datura stramonium or Jimson weed, which contains the alkaloids of hyoscyamine, atropine and scopalamine in the seeds, leaves, and roots."

Both children gradually improved so that by twenty-four hours after admission they had ceased hallucinating, the ataxia was no longer present, and they were completely aware of their surroundings. There was total amnesia of the preceding twenty-four hours. The skin was no longer flushed, the mucous membranes were moist, and the pulse had slowed and become regular, but the pupils were still dilated. Two days after admission their pupils were still dilated but did have some reaction to light. The patients were otherwise normal and were discharged.

Comment

Jimson weed belongs to the Solanaceae or nightshade family. Distribution is world wide and the plant grows wild in many areas of the U. S., attaining heights of 2 to 6 feet. It flowers in late spring with white, five-lobed trumpet-shaped flowers which have a strong sweet scent. The seed capsules are eggshaped and covered with sharp spines. The leaves are large, angular, and measure 4 to 6 inches in length. The plant is almost as old as history itself. It is believed to have been

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used in ancient Greece for its hypnotic and narcotic effects. It was used in India by thugs to drug their victims.[6] American Indians used it in ceremonies initiating boys into manhood and some tribes used it as an anesthetic.[2] Probably the first case of Datura poisoning in this country was that described by Robert Beverly in 1676.[3] Cases have been reported off and on since that time, among which are several deaths. The usual cause of death is due to respiratory failure.

The earliest toxic manifestations are flushed cheeks, dryness and burning of the mouth, thirst, and visual disturbances. The pupils become dilated and do not react to light or accommodation. Further signs are rapid weak pulse, elevated blood pressure and difficulty with urination.[1] Weakness, giddiness, staggering, mental confusion, excitement and delirium may follow.

Treatment varies with the severity of the manifestations. In mild cases withdrawal may be the only treatment necessary. In severe cases, lavage of the stomach with weak iodine, strong tea or 4 per cent tannic acid may be used, followed by giving the patient magnesium sulphate. Sedation may be used but the patient must be observed for respiratory failure in which case artificial respiration or stimulants may be necessary. In severe poisoning with a long recovery, nursing care is very important in the prevention of complications, such as pneumonia. Parenteral fluids may be used and be helpful, as will hydrotherapy if fever is present.[4] Pilocarpine may be used to help alleviate the dryness of the mouth and the visual disturbances, but it will not shorten the course of the intoxication.

Poisoning due to the ingestion of Datura stramonium or Jimson weed occurs not infrequently and will undoubtedly be seen more often as a result of the present trend of families to reside in suburban areas. This possibility should be included in the differential diagnosis of every case presenting bizarre symptoms and signs, which in any way suggest atropine intoxication.

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PERFORATION OF THE ESOPHAGUS

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Use and Abuse of Corticosteroids, Antibiotics and Antihistamines in Dermatology

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THE ENTHUSIASTIC reception of cortisone and corticotropin in the treatment of skin diseases has waned considerably during the past year. Warnings concerning their hazards plus the fact that their effects are only palliative are indicated.

It has been apparent since the first use of steroids in Dermatology five years ago that they did not cure patients with skin diseases. It is true that in some cases rather spectacular improvement occurred and that life expectancy can be extended in such fatal dermatological diseases as pemphigus and acute disseminated lupus erythematosus. The administration of these drugs may produce serious and prolonged reactions. These unfavorable and often serious sequelae may become manifest months after the administration of the drug is stopped. Patients differ greatly in their tolerance of these hormones.

The administration of cortisone and corticotropin suppresses the secretion of endogenous adrenocorticotrophic hormones by the anterior lobe of the pituitary body. O'Leary[3] has emphasized that in addition to the unfavorable side effects as noted in the skin, namely increased pigmentation, hirsuitism or alopecia, seborrhoeic-like dermatitis, acne, atrophic striae, and the "moon face" of Cushing's syndrome, it is necessary to bear in mind that cerebral disturbances such as euphoria, depression states, frank psychoses, convulsive attacks and changes in personality may develop. In addition, alterations in electrolyte metabolism resulting in retention of salt and water associated with edema and gain in weight may require adjustment in intake of sodium chloride and potassium. The transient hyperglycemia is usually readily controlled and disappears when administration of the drug is stopped, although the hypertension that frequently develops may persist and be serious. Intercurrent infections such as tuberculosis, peritonitis, streptococcic and staphylococcic infections and influenza may be masked by the administration of these drugs and accordingly over-looked. Other complications include the development of gastric or duodenal ulcers from which severe bleeding may occur or even perforation without warning, and interference with healing of operative wounds. Suppression of the adrenal cortical function may occur and be manifested by weakness, fatigability, and a drop in blood pressure. Contraindications to the use of these steroids include heart failure, hypertension, renal insufficiency, psychotic tendencies, duodenal ulcer and tuberculosis.

Beneficial Effects of Corticosteroids

It is now accepted that these drugs are not curative and that the favorable results of treatment in skin diseases is very variable. In those cases in which marked improvement can be expected, complete failure may occur and in others in which marked benefit is not anticipated, spectacular improvement may take place. The two diseases in which cortisone or ACTH are definitely indicated and may be life-saving, at least temporarily, are acute disseminated lupus erythematosus and pemphigus. They apparently are more effective in the vulgaris type of pemphigus than in the foliaceous and vegetative types.

In most cases of pemphigus the oral administration of 200 mg. or more of cortisone per day will stop the formation of blebs and blisters. In an occasional case the oral administration of 400 to 500 mg. of cortisone per day or the intramuscular injection of 100 to 150 units of corticotropin may be necessary to control the pemphigus. Oral administration of 50 to 100 mg. of cortisone or the intramuscular injection of 10 to 40 units of ACTH per day is usually necessary to maintain a remission. Potassium chloride and ascorbic acid are valuable adjuncts. When the administration of steroids is discontinued or its dose is reduced too rapidly, the cutaneous lesions usually recur. Such recurrent lesions are more severe and resistant to treatment than were the original lesions.

In a few cases of pemphigus the disease has been controlled without remission for three years with maintenance doses of steroid. In other cases of pemphigus the disease has not recurred even after maintenance doses have been discontinued. However, in these cases of supposed cure the question arises as to the accuracy of the original diagnosis. Unfortunately, many patients have not de-

rived any benefit from steroid therapy and have died of the disease.

In cases of acute disseminated lupus erythematosus of the severe systemic type administration of corticosteroids will frequently produce a remission that may be maintained for several years. Although such clinical remissions occur, laboratory examinations reveal little change. The L.E. cells persist as well as increased sedimentation rate, leukopenia, albuminuria and reversed A.G. ratio. Unfortunately, most clinical remissions are of short duration and the patients have eventually died of the disease.

In cases of sarcoidosis, lymphoblastoma, dermatomyositis, scleroderma, and acrosclerosis the results of treatment with steroids are unsatisfactory. Recently, injections of hydrocortisone into the local lesions of sarcoidosis has been reported by Herman Beerman and Associates[4] as producing rapid involution of such lesions although recurrence has occurred in less active form.

There is a great temptation to use steroids in the treatment of atopic dermatitis. Temporary relief can be secured by such therapy but relapse invariably occurs often with exacerbation of symptoms and frequently associated with severe depression and suicidal tendencies. The feeling of well-being, euphoria and clinical improvement in such patients rapidly brings on addiction to the steroids and this addiction is often as difficult to break as the morphine habit.

Uncomplicated psoriasis should not be treated with these steroid drugs. However, when complicated with exfoliative dermatitis or psoriatic arthritis its use may be justified but recurrence can be expected.

ACTH and Cortisone will probably prove of greatest service in acute self-limited dermatoses. Such recommendation, however, will depend upon further experience with the delayed serious reactions that seemingly may occur even after small doses of steroids. In general, they should not be used in chronic recurrent non-fatal dermatoses which can be managed with conventional methods. The most gratifying results are seen in severe penicillin urticaria and severe dermatitis medicamentosa. Its use is indicated in severe erythema multiforme of the Stevens-Johnson type and anaphylactoid reactions. It may be justified in severe dermatitis venenata such as poison ivy where highly gratifying results can usually be obtained. Unless the cause is recognized and no longer acting, however, steroids should not be used.

Hydrocortisone acetate ointment in strengths of 1 and 2½% for local use has recently become available. It has proven very effective in many cases of contact and allergic dermatoses. It has also been a valuable addition to the treatment of localized patches of neurodermatitis and pruritus ani and vulvae. Fortunately, there is evidently so little absorption from such local use that systemic toxic manifestations have not been reported to date. Unfortunately, it is so expensive that its use is not practical except in small localized patches of dermatitis.

In conclusion, the use of Cortisone and ACTH should be limited to the following conditions:

1. Serious and otherwise fatal conditions, such as pemphigus and systemic lupus erythematosus;
2. Self-limited hypersensitivity reactions of severe degree unresponsive to more conservative measures;
3. Steroids should not be used in chronic recurrent non-fatal dermatoses which can be managed with conventional methods;
4. Hydrocortisone ointment used locally is seemingly effective in contact and allergic dermatoses, localized neurodermatitis and pruritus ani.

Antibiotics

The first and still the best antibiotic for systemic treatment of acute cutaneous pyogenic infections is penicillin. It is not recommended, however, for local treatment because of the high incidence of cutaneous sensitivity reactions which occur as the result of topical application. Many newer antibiotics are being used in the treatment of various skin infections such as impetigo, ecthyma, pyoderma, erysipelas, cellulitis, and lymphangitis. These include aureomycin, terramycin, neomycin, bacitracin, polymixin B and more recently erythromycin and achromycin. These latter antibotics are uncommon sensitizers when used locally. Some of these antibiotics, such as neomycin, bacitracin and polymixin B, are used primarily for topical application and not for systemic use. There is an advantage in selecting them for local use rather than those that are extensively used systemically since, if sensitization does occur, it will not deprive the patient of a useful drug for possible future systemic treatment should a serious infection occur.

Antibiotics when used locally are usually applied as ointments. Their use in watery solution or wet dressings is often more effective than in ointment bases. They should be used in concen-

trations of from 0.1 mg. to 1.0 mg. per c.c. The powdered antibiotics may also be added to lotions in a concentration of 1 mg. per c.c. when indicated. Neomycin sulfate and polymixin B are stable in aqueous solutions for indefinite periods, but aureomycin, bacitracin and terramycin are unstable in solution. These latter antibiotics should not be prescribed in an ointment base or lotion containing water.

The *in vitro* results and preliminary clinical experiences with erythromycin indicate that it is very effective for both hemolytic streptococci and staphlococcus aureus. Since these organisms are the cause of the vast majority of skin infections, it should prove the most uniformly effective of all the antibiotics. The results of *in vitro* sensitivity tests of the more common antibiotics may be summarized as follows according to Clarence S. Livingood:[2] For staphylococcus aureus the order is erythromycin, neomycin, terramycin, penicillin and bacitracin; for hemolytic streptococci the order is erythromycin, penicillin, terramycin, aureomycin, bacitracin, and neomycin.

No single antibiotic is superior for all infections. Of late, there is a tendency to employ a combination of antibiotics in ointments instead of a single preparation in order to secure more efficiency. Unfortunately, no such combination is uniformly effective. Ideally, bacterial cultures and in vitro sensitivity tests should be made to the causative organisms in selecting the most suitable antibiotic for local or systemic use. This is especially indicated in chronic resistant infections. If such sensitivity tests cannot be done, selection should be made on a trial and error basis. If marked improvement with a given preparation does not occur within a week a different antibiotic should be selected. It is desirable in making a selection of an antibiotic to be employed, to be familiar with the evaluation of its therapeutic efficiency for the type of infection present.

Penicillin is still the treatment of choice for both syphilis and gonorrhea. There is no evidence to date of penicillin resistance developing in either of these diseases. There is, however, an ever increasing incidence of penicillin sensitization which may limit its use more and more in the future. Penicillin is of no value in the treatment of chancroid, lymphogranuloma venereum, or granuloma inguinale. It is commonly used in the treatment of chancroid and such use masks a possible syphilitic infection if present. The treatment of choice for chancroid is sulfonamide therapy. Sulfonamides are also of value in the treatment of lymphogranuloma venereum. The mycins, except for streptomycin in syphilis, are effective in the treatment of all five of the venereal diseases, although they are the treatment of choice only in lymphogranuloma venereum and granuloma inguinale. Although they are not as effective as penicillin in the treatment of syphilis and gonorrhea, they are suitable substitutes if severe penicillin sensitivity exists. They may also be used in the treatment of chancroid if contraindications to the use of sulfonamides exist, although such use will also mask an associated syphilis if present.

The sulfonamides, although not antibiotics, are valuable in the treatment of skin infections. They, however, like penicillin, should not be used locally because of the frequency of cutaneous sensitivity from such use. The common practice, particularly in the past, of employing sulfathiazole ointment to leg ulcers and stasis dermatitis, frequently caused severe dermatitis venenata or medicamentosa. Sulfapyridine, which has little other value and is one of the more toxic sulfonamides, is most effective in the treatment of dermatitis herpetiformis and some cases of so called nummular eczema. Frequent blood counts and urinalyses should, however, be made on such patients.

Antihistaminic Drugs

Histamine plays an important role in the phenomena of hypersensitivity. Antihistamines should neutralize, or at least inhibit, the effect of histamine in allergic skin diseases. When introduced it was hoped that they would prove highly effective in the control of all types of allergy. Unfortunately, further experience has not justified this hope.

The exact mechanism of action of these drugs is not known. They are not effective in all allergic manifestations and are not universally useful in any particular syndrome. They may provide symptomatic but not curative relief for urticaria, angioneurotic edema, and serum sickness. They have been a disappointment in atopic and contact dermatitis where their value is largely limited to their sedative effects.

These drugs are often helpful in controlling pruritus when used locally due to their anesthetic action. They have, therefore, been recommended for the control of pruritus in localized neuro-

dermatitis, lichen planus, pruritus ani, etc. Such local use is, however, no longer recommended because of the high incidence of cutaneous sensitivity reactions which occur as the result of such topical application. Preparations containing antihistaminics for local application, therefore, are no longer approved by the Council on Pharmacy and Chemistry of the American Medical Association, or listed in *New and Non-Official Remedies.*

An important limitation to the systemic use of these drugs is their toxic effects. The major undesirable symptom, particularly to their ambulatory use, is sedation. This may be evidenced by inability to concentrate, loss of alertness, dizziness, weakness or marked sleepiness. In occasional cases excitation occurs, manifested by tachycardia, nervousness, irritability, or insomnia. In other patients, nausea, vomiting, headache and blood dyscrasias, such as agranulocytosis, anemia, and leukopenia may develop.

The large number of antihistaminic drugs being presented these days is very confusing. It is impossible to be experienced with them all. It has been suggested by Feinberg[1] that these preparations be divided into three groups and that the practitioner become acquainted with at least one preparation from each group. *Group one* might comprise the less sedative and usually less potent antihistaminics, such as Antistine, Neohetramine, Perazil, and Thephorin. *Group two* would comprise the more potent and moderately sedative members, such as Chlor-Trimeton, Histadyl, Neo-Antergan, Pyribenzamine, Pyrrolazote and Trimeton. *Group three* might contain the most sedative drugs, such as Benadryl, Decapryn, and Phenargan. It is suggested that the physician select one member from each of these groups. Selection from such a triad would satisfy the majority of the cases who respond to antihistamines.

It may be indicated in some cases with severe allergic manifestations to increase the average adult dose from two to four times. When using such large dosage, however, the patients should be under constant observation. The use of antihistaminics suitable for intramuscular or intravenous administration such as Benadryl, Histadyl or Chlor-Trimeton often produce more prompt and powerful action than their use orally. Such use is ordinarily restricted to emergencies and such situations are often more effectively met by the use, if available, of corticosteroids.

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POLIO VACCINE CONFUSION AND FACT

(Continued fom Page 656)

The Council in originally adopting a policy of PR foresight.

This preliminary review is in no way intended as an "I told you so" paean of self-praise; too many problems still lie ahead. Nevertheless the Michigan medical profession is justified in being rather proud that its concept of public relations has a stronger foundation than mere "co-operation" in or acquiesence to such an obvious and popular measure as "free" polio inoculations. In this instance, courage was a basic ingredient in an increasingly successful PR activity. Lacking courage, MSMS never would have accepted what its leaders considered a sincere responsibility to give facts to the people of Michigan no matter what the cost (in "popularity").

Economic Advantages of Early Ambulation

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THE HIGH COST of medical care, particularly hospitalization, has become a matter of vital concern everywhere, to the patient, to hospital management, to the medical profession, to insurance companies and to the community as a whole. Hospital costs naturally have soared because of the general inflationary trend, but the problem has been further aggravated by abuse of hospitalization because of prepaid hospital insurance. This economic problem must be solved, or hospital care will soon be priced beyond the reach of a majority of those who need it, whether it is paid directly or through hospital insurance premiums. A significant contribution to the solution of this problem could be made by reducing the average period of postoperative hospitalization, since the majority of admissions in community and private general hospitals are surgical and obstetrical. Fortunately, the means are already available for doing this, if all surgeons would take advantage of recently improved methods of postoperative care, for these methods result in more rapid recovery of the surgical patient, and definitely shorten the hospital stay. Development of these procedures was motivated originally by the desire to improve medical care, but their enormous economic advantage furnishes another compelling reason why they should be more widely and effectively applied.

Hospital Stay Can Be Reduced

In our practice, through use of early ambulation, the average period of hospitalization after over 4,000 major surgical operations performed since 1938 has been reduced to less than half the time required in a comparable series of cases observed earlier, when patients were confined to bed after operation. In a large series of consecutive cases, the period of hospitalization after appendectomy was reduced from eight to two days; after cholecystectomy, from fourteen to seven days; following herniorrhaphy, from fourteen to five days, and following hysterectomy, from twelve to six days. In many individual cases, the hospital periods have been considerably shorter than these averages.

Reduction of hospital stay by at least 50 per cent has been reported also by other surgeons who have applied early ambulation aggressively and consistently. Despite enthusiastic reports from many surgeons, the general statistics on the length of hospital stay demonstrate clearly that many surgeons are still not achieving the maximum benefits possible with modern methods, because they are not using early ambulation with sufficient emphasis and insistence, particularly in patients who have been subjected to extensive procedures. In 1953, among patients insured in the Blue Cross, representing 45.8 per cent of all hospital admissions in the State of Michigan, the average period of hospitalization for all uncomplicated major surgical cases was still thirteen days. Since this figure represents the total period before and after operation, the postoperative period would probably be one to one and a half days less. This still leaves a considerable discrepancy between what can be done and what is being done generally.

Professional Attitude Toward Early Ambulation

That this matter has great significance from the standpoint of cost of hospital insurance in the aggregate and for every individual who is insured is emphasized in a letter sent by the Chairman of the Advisory Committee of the Michigan Hospital Service, in December, 1953, to all physicians in the state. This letter stated that the length of hospital stay has "crept up since 1951," and warned that "should the average length of stay increase by one day it would cost Michigan Blue Cross $10,000,000 in 1954."

When this letter came, it recalled another letter once received from the Wayne County Medical Society, after I had begun to advocate early ambulation after surgery, on the basis of my own favorable experiences. This earlier letter is mentioned because it is pertinent to the present discussion in explaining why the full impact of the modern therapeutic methods has not yet been realized in the practice of surgery generally. The letter, dated September 26, 1939, reads as follows:

> "The Ethics Committee has obtained legal opinion to the effect that if some untoward results should follow such a short stay in the hospital after an operation and should result in a lawsuit that the defendant (the physician) could not anticipate a favorable decision. It is also the opinion of insurance companies that they would tend to avoid the handling of such a case."

These two letters testify that within a little more than a decade there has been a complete reversal in the official attitude of the medical profession in regard to the optimal period of hospitalization after surgery. It is historically interesting and indicative of the rapidity of recent medical progress, that the shortening of hospital stay which was criticized and censured in 1939 has attained such status by 1953 that the insurance organizations sponsored by the Michigan State Medical Society urge all doctors to practice it because of its corollary economic advantage.

In this connection, it also should not be forgotten that the attitude of active opposition to early ambulation after surgery persisted for several years. In 1940, when results on early ambulation were presented before the Detroit Academy of Surgery, the discussion, in general, was ruthlessly antagonistic.* There was no widespread acceptance nor general application of early ambulation after surgery until about 1946, although a few surgeons in the larger medical centers had experimented with the method prior to that time. This means that the general trend toward methods that promote rapid recovery has taken place entirely within the past ten years. In view of this, it is not surprising that the maximum benefits possible with this new procedure have not yet been fully realized by the entire profession. It is perhaps more surprising, when one considers the natural conservatism of the profession, that the newer methods have been so thoroughly tested within such a short time, that they have received official sanction and that medical teaching in regard to postoperative care has changed so radically.

The majority of surgeons now in active practice received their training more than ten years ago, when it was believed that constant bed rest was required for wound healing, though this is now known to be a fallacy. Early ambulation was either unheard of or definitely frowned upon (as proved by the letter cited) as a hazardous procedure. Because of their training, many of these older men are naturally skeptical about the merits and safety of early walking after surgery, especially if they are working in small communities where they have not had the opportunity to observe the beneficial results at first hand. Even though they may recognize the possibility of beneficial results in theory, timidity frequently inhibits them when it comes to actual practice. Such timidity is usually attributable to certain misconceptions caused by incomplete understanding of the physiologic principles on which the rationale of early ambulation is based.

Why Early Ambulation Is Necessary

In my previous publications, the physiologic necessity for ambulation immediately after operation has been fully explained.* After an operation, because of noxious reflexes initiated by the surgical injury, the arteriolar bed as a whole contract, choking off the blood supply to the organs and voluntary muscles. Similar contraction also occurs in the bronchioles and air cells, thus reducing oxygen content in the blood which supplies nourishment to the various organs and voluntary muscles. Oxygen lack and the accompanying imbalance in body fluids and electrolytes account for the weakness after an operation, which is usually in direct proportion to the magnitude of the surgical procedure. Walking reverses this functional imbalance and cripppling by substitution of a strong counter or compensatory reflex, demanding more oxygen for the muscles. This stimulates a chain reaction of biochemical responses resulting in opening of the bronchioles and arterioles, so that pulmonary ventilation is improved and blood flows to the viscera and extremities more rapidly. The patient's general physical improvement, as a result of this, is almost unbelievably prompt, as can be demonstrated by the "rapid recovery experiment."

"Rapid Recovery Experiment"

Early in our investigations on early ambulation, the "rapid recovery experiment" was so called because it was used when the patient's general condition demanded a particularly strong stimulus for re-establishment of normal function, or to furnish a striking demonstration of the immediate effects of exercise to fearful patients and doubting observers. At present, however, this "experiment" is

*Dr. Roy D. McClure was the only one present who expressed an objective interest and urged that the investigation be continued. Early encouragement also came from Dr. Alexander W. Blain. An article on the results of these experiments, prepared in 1939, was rejected by four national surgical journals. It was finally published in 1941 in the Archives of Surgery, but only after intercession and recommendation by Dr. Anton J. Carlson, Professor of Physiology at the University of Chicago, who had been impressed with the soundness of the physiologic principles involved, after a thorough review of the author's data.

*These principles are also emphasized in a motion picture film produced in 1944, which also demonstrates the "rapid recovery experiment." This film is available for loan to medical organizations and hospital staffs upon request.

now incorporated into the postoperative regimen as routine practice; *three times out of bed in rapid succession immediately after recovery from the anesthetic is a standard order and is supervised by nursing personnel.*

Every surgeon can convince himself of the value of immediate postoperative exercise if he will perform this "rapid recovery experiment" on a patient who has undergone a major operation, e.g., cholecystectomy or gastrectomy. Immediately after the patient recovers from the anesthetic, assist him to get out of bed from the recumbent position and instruct him how to do it. Have him turn on his right side, then sit up with his feet over the edge of the bed, stand on the stool, then step down to the floor. Have him walk a few steps and then return to bed and resume recumbency, for about a minute. Then repeat the procedure twice. Each of the three times that he gets out of bed, insist that he walk as many steps as possible; each time he will be able to go farther. After this exercise period (about five minutes) is completed, allow the patient to rest in the recumbent position for ten minutes, and then visit him again. You will be amazed at the improvement in his general condition.

The surgeon should perform this experiment personally on three different patients; by then he should be so thoroughly convinced of its efficacy that he will be ready to adopt it as routine procedure, and to train his assistants and nurses in the management of patients during this immediate postoperative exercise. After this first "triple-rising" procedure, most patients can get out of bed by themselves, without assistance, and they are instructed that walking should be repeated frequently. If the patient is somewhat resistant or fearful, then each time he gets out of bed, have him bend over and touch the floor several times; this relieves any feeling of faintness and gives the patient confidence. If the patient should be still lagging or fearful on the day after operation, urge him to walk more rapidly or to walk up a flight of stairs. Encouragement and aggressive insistence are necessary to instill confidence in some patients, and become routine responsibilities of surgeons, interns and nurses in hospitals where early ambulation is effectively practiced.

Early Ambulation Hastens Wound Healing

Fear of wound disruption, which apparently still lurks in the minds of many surgeons, is absolutely groundless, as has been proven by all authors who have written on early ambulation. Actually, the wounds of patients who exercise immediately after operation heal more rapidly, and in all reported series, the incidence of incisional and recurrent hernias has been greatly reduced. Every surgeon who believes in his own technical ability to make a proper incision and to suture a wound securely can apply early ambulation effectively (which means radically) and consistently in all cases, with perfect confidence that his patients will recover more rapidly and that there will be far less danger of wound disruption and other complications than there would be if they were kept in bed for several days after operation.

Immediate Postoperative Walking Decreases Complications and Hospital Costs

In focusing attention on the economic aspect of the problem, the most important factor is timing, since the beneficial results are directly dependent on when (that is, how early) ambulation is established. When a surgeon understands the underlying physiologic principles, he knows why the earliest possible moment is the correct time to have the patient walk after an operation, and then he achieves effective results. He understands why "dangling" is a poor excuse for walking. "Dangling" and periods of sitting in a chair for several days before ambulation is started are undoubtedly responsible for certain reports that ambulation does not prevent venous thrombosis and consequent fatal pulmonary embolism. Early and frequent walking exercises beginning immediately on recovery from the anesthetic promote acceleration of the blood flow which washes away sludge and sticky clumps of red cells before they have time to become large fatal clots.

When the time of getting out of bed is left up to the patients (a relatively common practice), then only the more vigorous and active persons, who need it less than others, get the benefits of early ambulation. The ones who offer resistance and elderly patients and those more severely ill, who need ambulation the most, do not get it. Patients in these groups are the ones in whom postoperative complications may develop. Such complications always lengthen the period of hospitalization, increase expense for the patient (and incidentally, for the hospital and the community), besides causing him undue suffering and sometimes risk to his life.

Misuse of Hospital Facilities

Failure to comprehend these facts is extremely harmful, from the standpoint of optimal surgical care, and also extremely costly. If every surgeon in the State of Michigan were to use early ambulation, with proper timing, and with insistence on a consistent program that would yield full therapeutic benefits, the average period of hospitalization for surgical cases could undoubtedly be reduced by several days. Since the costs of hospitalization are constantly increasing, it becomes the duty of every surgeon to take advantage of the recent improvements, not only to hasten recovery and reduce the risk of complications, but also to ease the economic burden for the patient. Each day of hospitalization that is not definitely necessary represents unjustifiable waste and is depriving some other sick person of hospital care.

In a study conducted by the Michigan State Medical Society and the Michigan Blue Cross in which over 12,000 consecutive clinical records in twenty-five typical Michigan general hospitals were analyzed, Becker has reported that more than 28 per cent of all hospital admissions "contained some element of faulty use" which was more frequent among insured patients. Blue Cross members misused their hospital stays in nearly 36 per cent of the cases. In terms of hospital days, 11,172 of 76,238 days studied were deemed unnecessary to the recovery, safety or reasonable comfort of the patient. "Nearly one out of five days used by a Blue Cross patient was not a necessary day." Over 18 per cent of Blue Cross patients remained in the hospital in excess of their need. Becker has also emphasized the abuse of hospital facilities through admissions for laboratory and x-ray studies that could be handled much more economically on an out-patient basis. The figures cited indicate that unnecessary hospitalization is a practical problem of great magnitude. To solve it, every physician and every surgeon must co-operate by using methods that reduce the necessity for hospitalization to the minimum consistent with optimal medical care.

Trend of Future Developments

The possible advantages of early ambulation have by no means been completely exploited, even by those of us who have studied it most thoroughly and applied it most vigorously. Observations in selected cases, following various surgical procedures, have furnished convincing evidence of this. Recovery has been so rapid in some instances that patients have been allowed to leave the hospital the day following cholecystectomy and herniorrhaphy, and dismissal on the day after appendectomy is a fairly common occurrence. In no instance of this type has there been any untoward development or complication. In fact, patients who have left the hospital earlier than usual and have regulated their own activities have displayed exceptionally and almost unbelievably prompt recovery. When early ambulation is practiced aggressively and the value of exercise is constantly stressed, the patient's attitude changes, so that he no longer boasts of how desperately ill he was, nor of how long he was incapacitated. Instead, he gets his satisfaction and makes his bid for attention on the basis of his superior accomplishments in achieving recovery at the earliest possible moment. He becomes proud of what he *can* do, instead of what he cannot do. Desirable psychologic attitudes and increased activity, each enhanced by the other, are the two essential factors which hasten recovery and reduce the hospital stay.

In the future, the architecture of hospitals and the planning of floor space will be modified to conform with modern practices. The function of the recovery room for the surgical patient will be expanded to include instruction in the proper method of getting out of bed, with supervision of his first ambulatory period, which is so important from the standpoint of rapid recovery, by skilled professional personnel. Then, when he returns to the surgical floor, he can care for most of his own needs under less highly trained supervisors and ward assistants. On the convalescent floor, a cafeteria dining room will be available where he will choose his own food, serve himself and enjoy sociable companionship with other patients during meals. This will represent a saving to the hospital by eliminating unnecessary service and reducing food waste. An improvised dining room of this type at our hospital has been enthusiastically accepted by the patients, during a two-year experimental trial. The foregoing is but a small sampling of possibilities for the near future.

As more and more experience is gained by the entire surgical profession, as hospital structures and routine functions are modified to conform to present methods and needs, and as more patients learn to assume a positive attitude toward rapid recovery after operation, it seems certain that the majority

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Michigan Veterans Trust Fund

By Lawrence J. LaLone, Executive Secretary
Lansing, Michigan

WE ARE grateful for this medium and this opportunity to tell the Veterans Trust Fund story to the members of the medical profession in our great state. We welcome this opportunity not only because our organization has paid over $2,000,000 in medical and hospital bills for Michigan veterans and their families since we started operations in 1946—but also because these and other needs that this organization was designed to meet will be with us for years to come. With some 40 per cent of our grants going for medical emergencies, it behooves us to work closely and harmoniously with those whose services are so essential to veterans and their families in time of need.

The scope and mission of the Michigan Veterans Trust Fund Board of Trustees have been broadened extensively since this program was first organized some eight and a half years ago, but, fundamentally, the mission is to provide financial assistance to meet the emergent needs of qualified World War II and Korean veterans and their legal dependents. However, rehabilitation is really the primary objective and, in addition to financial assistance, we consider it our mission not only to help applicants through the resources of our own organization but also to refer them to other resource agencies, private as well as public, "to help the man to help himself." In this connection, all applicants are expected to make every possible effort to solve their problems through their own resources, within reason. But on the other hand, assistance should be and is granted in those cases where the applicant would undergo undue or dire hardship unless outside assistance was forthcoming.

The "$50,000,000 Trust Fund" story actually goes back to 1943 when the Michigan State Legislature transferred $50,000,000 from surplus (believe it or not, the state had a surplus in those days) in the state treasury to a postwar reserve fund for the purpose of "liquidating Michigan's obligation, after termination of the war, to its returning servicemen, their widows and dependents."

Subsequently, Act No. 9 of the Public Acts of 1946, 63rd Legislature, Extra Session, was unanimously passed by the Legislature. This act created the Michigan Veterans Trust Fund and its Board of Trustees, giving it control of the $50,000,000 fund and outlining, in general terms, provisions for its administration.

The fund is administered entirely by World War II and Korean veterans, solely for the benefit of honorably discharged veterans of World War II, Korean veterans and their dependents.

This aid is granted for temporary emergent needs of qualified veterans and their dependents and is in no sense intended to be a continuing fund or a public assistance fund that will duplicate already existing agencies set up to render assistance to individuals with chronic or long-range requirements.

Only the earned income from the corpus of the $50,000,000 Trust Fund is utilized in making these grants to veterans. The earnings approximate $1,171,000 a year. That is the gross annual return. However, at the time this fund was invested in government bonds, the $50,000,000 was able to purchase only $47,000,000 in bonds at the then-price of the bonds. The Michigan State Treasurer, who is custodian of the fund, is amortizing the premiums on these bonds, as any trust company would do, so that whenever the bonds come due, by setting aside a certain sum from the earnings each year, the state will still have its $50,000,000 intact. In other words, by utilizing only the earned income, the program is able to render millions of dollars in assistance without using any of the taxpayers' money from the general fund.

Each of the eighty-three counties in the state receives its respective share of the earnings from the fund, based on the veteran population in each county (as determined from time to time by the Board of Trustees) and all such allocations remain to the credit of the respective counties. Any portion of the county allotments unused at the end of a fiscal year carry forward and are added to subsequent allotments.

In order to take advantage of the maximum earning capacity of the earned income, disbursements to the counties are confined to amounts required to meet needs of the immediate future. However, any county may at any time request any portion, or, for that matter, all of its undisbursed allocations, if conditions in the county warrant such action.

Disbursements of funds at the county level are

made by the respective county treasurers directly to the beneficiaries or vendors upon order of the local county committee.

In its broadest sense, need is defined for the purpose of this act to be any emergency in the life of an honorably discharged World War II veteran, Korean veteran and/or his or her dependents which requires immediate assistance in order to prevent dire and undue hardship to the applicant.

The emergencies may involve hospitalization, medical services which cannot be secured from any other federal, state, or county agency or from any privately owned insurance coverage; food, fuel, clothing, shelter, necessary transportation, or other unforeseen emergencies requiring prompt attention.

As an indication of the autonomy as well as the latitude that county committees enjoy under the broad provisions of our program, we have granted as little as $5 for a bus ticket, and we have paid over $2,000,000 in hospital and medical bills for individual veterans and their families.

Since we started operations on July 1, 1946, our eighty-three county committees have approved over 100,000 applications and have expended nearly $6,000,000 in behalf of these applicants and their families. As we mentioned earlier, over $2,000,000 of this amount was for the payment of medical and hospital bills. Approximately $3,000,000 was spent for subsistence items—food, clothing, shelter, et cetera. And as we pointed out, all of this money has been granted at no expense to the taxpayers because the State of Michigan will eventually get its $50,000,000 back, as we use only the interest from the corpus of the fund.

The Michigan Veterans Trust Fund is the state's official agency for most matters involving Michigan veterans (particularly those nonservice-connected in nature) but time and space preclude any detailed summary of these other responsibilities. For instance, our Student Loan Fund, which our organization administers, has made it possible for over 10,000 Michigan students to continue their education when many of them might have had to drop out but for timely loans from this fund. Unlike the Trust Fund program itself, which involves outright grants, the Student Loan Fund, as the name implies, is a revolving fund where individual loans up to a maximum of $100 are made to veterans when their regular subsistence checks from the federal government are delayed, lost, et cetera. Since July 1, 1946, we have loaned some $700,000 to eligible students through the revolving provisions of this program.

Suffice it to say, that Michigan has good reason to be proud of the national recognition it has received as a leader in providing for the needs of her veterans. In recognition of the generosity of the people of Michigan, those of us charged with the responsibility of administering this program recognize that these privileges entail adherence to the strictest principles of sound and economic administration, coupled with prudent judgment. To that end, it is the goal of this program to help veterans to help themselves and to be worthy of the traditionally American concept that those who served in our armed forces in the hour of our nation's greatest need should themselves be served in their hour of need.

ECONOMIC ADVANTAGES OF EARLY AMBULATION

(Continued from Page 700)

of surgical patients will require only one or two days' treatment in the hospital following all but the most formidable surgical procedures. When that time comes, it will bring with it the saving of millions of dollars in the State of Michigan alone.

Summary and Conclusions

1. Early ambulation after surgery promotes rapid recovery, prevents complications and shortens the hospital stay.

2. To be maximally effective, early ambulation must be instituted *immediately* on recovery from the anesthetic, as demonstrated by the "rapid recovery experiment."

3. If *all* surgeons would apply this practice effectively and conscientiously, the hospital stay of surgical patients would be reduced, on the average, by several days.

4. By this means, hospital facilities could be used more efficiently, and hospital costs and the cost of prepaid hospitalization insurance could be reduced. This would save millions of dollars each year in the State of Michigan.

President's Message

Edict or Ethics

An undercurrent of discussion is prevalent among Michigan doctors of medicine. It concerns the powers of the Michigan State Board of Registration in Medicine. And it concerns the inability of the organized profession of medicine to exercise discipline of its own membership. The finger of the Michigan court points to the Board of Registration as the only disciplinary body in authority. Discussion revolves upon how much and what authority should this Board have. Thought is also directed to the medical society and its responsibility in matters of professional misconduct.

Our attention is invited to a recent law passed in the State of Washington, and sponsored by members of the Washington State Medical Society. We do not have the details of how this law is to be administered. But it is directed at authorizing "disciplinary action against licensed physicians who are guilty of professional misconduct."

Perhaps our Michigan State Board of Registration needs its authority more explicitly defined. Certainly, professional misconduct needs definition. So much of what may be called, by some, professional misconduct is truly not a matter for law but rather a matter of ethics. The AMA Principles of Ethics are basic for our profession. Many other attempts have been made to list codes of behavior for doctors of medicine, a recent one appearing in the March 1954 issue of *The Modern Hospital.*

We believe that we should not entrust to law the definition of good moral conduct nor apply legal penalties in an attempt to legislate morals. Such attempts have failed in American experience.

It will require sharp discrimination to separate the legal responsibilities of the practising physician from his basic moral obligations to his profession and the public.

Robert H. Baker
President, Michigan State Medical Society

Editorial

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
Civic Auditorium—Pantlind Hotel, Grand Rapids
Wednesday-Thursday-Friday, September 28, 29, 30, 1955
YOU are invited to attend the Ninetieth

MICHIGAN MEDICAL SERVICE

Medicine's Answer

THIS MONTH, we again salute the medical profession's answer to the threat of socialized medicine. In the course of events, the answer had to come. The time was right for an excursion into the realm of providing prepaid, voluntary medical and hospital care for a people deep in the despair of a long-continued depression, with not much hope for better things. The profession asked the regular insurance companies to offer some relief and were told that prepaid medical care was uninsurable. Some of our national medical leaders suggested we practice medicine and keep out of insurance.

In Michigan and some other parts of the country, local groups refused to give up. The Blue Cross-Blue Shield movement was almost spontaneous, the most spectacular growths ever witnessed, and Michigan was in the vanguard. We started with some ideas and a borrowed $10,000. Blue Shield, Michigan Medical Service, is now a great public trust, protecting 3,243,431 persons (January, 1955) in our state. (Blue Cross has 3,369,231)

In conjunction with Michigan Hospital Service, our service plans own a grand home office building valued at $3,250,000. Michigan Medical Service has a healthy reserve of almost $7,500,000 and has paid out in behalf of subscribers up to February 28, 1955, $155,238,311.30.

The Michigan State Medical Society and every member should be justly proud of such achievement. It represents untold hours of attending organizations and administrative meetings, and, on the part of our pioneer doctor of medicine in the earlier years at least, literally thousands of hours of automobile driving, alone and at night, in order to give the needed service and return to our patients waiting at home.

We salute the attained "miracle," but we also salute those men of vision who would not give up, even under tremendous stress and coercion.

TAKING A TRIP?

A GREAT many of our doctors and their families take trips abroad in these days of fast travel and many international meetings. Our patients also have the same notions. All who travel in foreign lands must take certain definite precautions. The San Diego Department of Public Health has prepared a pamphlet, copied with permission by the Calhoun County Health Department. Several items are given emphasis.

"Be vaccinated, depending on the area of travel, against typhoid, paratyphoid, smallpox, typhus, cholera, yellow fever. Do this early enough to be well protected.

"One should have a complete medical check-up. The doctor will advise about medication to take along, because this might be difficult or impossible to get in some places. A simple First Aid Kit is important, look after teeth, have an extra pair of glasses.

"Watch your food and drink. In some places eat or drink nothing that has not been recently boiled or cooked. Avoid ice, ice cream, milk, butter, cheese, raw fruits or vegetables, salads, raw meats. The United States Consul is a safe friend in case of illness or trouble."

Don't try to take a shot of insulin in a plane 15,000 feet high without first equalizing the pressure within the bottle—you might break your syringe.

We have made these suggestions because they might easily be overlooked.

ETHICS BY RULE

THE JUDICIAL COUNCIL of the American Medical Association, at the Miami meeting, November-December, 1954, made a report (accepted by the House of Delegates) from which we quote:

". . . Ophthalmologists cannot ethically provide glasses for their patients unless the service is unavailable without hardship or inconvenience to the patient.

"It is unethical for ophthalmologists to profit from the sale of glasses.

"Ophthalmologists cannot derive income from merchandising and still be considered on a professional level.

"Ophthalmologists may not accept rebates from optical houses.

"It is unethical for an ophthalmologist to profit from the services of an optician working either in his office or on a referral basis . . ."

We contacted the general manager of the American Medical Association regarding this report and were told that before arriving at the above statement, the Judicial Council had written to the officers of the Section on Ophthalmology of the American Medical Association, The American Academy of Ophthalmology and Otolaryngology, and the American Ophthalmological Society asking whether they considered it ethical to receive profit from the providing of glasses to patients. The answer to this basic question should be given only after thorough canvass of the membership. This was not done, however. The opinion obtained was not representative of the membership. The officers questioned are men who have retired from practice, are practicing surgery, or are engaged in teaching ophthalmology, and probably have not refracted eyes for glasses in private practice for years.

If only rebates were contemplated, which was evidently the impression, we all deplore them. (Incidentally, one man could have qualified to speak officially for all three groups. Three did.)

About 80 per cent of ophthalmology is concentrated in fitting glasses and making the patient see comfortably. If a doctor does the finest and most accurate refraction, then sends his patients out to hunt for glasses, both will be disappointed. Fully one third of the comfort in wearing glasses is in the proper frame selection and fitting. Unless the doctor attends to it himself, the patient will be unhappy, will return to the optician and be told the doctor *must have made a mistake*—a black eye for the doctor.

We believe that complete service is what the patient expects and has a right to receive. The Michigan State Medical Society, at one of its annual sessions, stated its belief that the complete fitting of glasses is just and ethical. We do not believe the providing of glasses is in any way merchandising. If the ophthalmologist assumes the complete service, he is entitled to make a suitable charge. He furnishes materials, looks after his own collections, and is under as heavy expense as those in any field of medicine.

The Judicial Council also declared that a doctor must not dispense drugs or have any interest in a pharmacy. He must in no way make a profit from medication he prescribes. How ridiculous can one be? Under such an interpretation, one does not dare hold stock in any of the well-known drug houses.

TRADE MARKS AND REGISTRATION

A FEW days ago, we received a strong letter from the Patent Counsellor of one of the large pharmaceutical manufacturing companies protesting the use of the trade-marked name of a drug in one of the articles in the February JOURNAL. We have had several letters of this nature in the years past. When we know and recognize a trade-mark name in a paper submitted for publication, we have been indicating it with a special mark ® or by capitalizing.

Some years ago, one of the big manufacturers sent us a list of their trade-mark names, several hundred in all. The list from this company the other day was one hundred and eighty-seven.

We have no disposition in any way to contribute to loss of a manufacturer's rights by mentioning names of articles and forgetting, but mostly not even knowing, that they are trade-marked. Our authors who contribute papers are not intentionally conspiring against the manufacturer.

We in the editorial office, as well as the proof readers at the printer's office, do not have, and do not know of an all-inclusive listing of these trade-mark protections, nor do we have the list from any specific company except when an incident occurs as did in our February JOURNAL.

If an all-inclusive master list of all trade-marked pharmaceuticals is available, we might use it even though an unusual burden would be imposed requiring that every drug name mentioned be compared with the list. If any of our authors or authors-to-be read this comment, will they please properly indicate the sign of registration (®) in their writing? This would be a help to all editors, and the manufacturing pharmacists should be thankful.

BEAUMONT MEMORIAL

THOSE of us who have followed the action of several thousand members of the Michigan State Medical Society as reported in THE JOURNAL will be pleased and proud that these generous

donors have completed and given to the State of Michigan a lasting memorial commemorating the pioneering work in digestion.

On June 2, 1822, a young doctor, William Beaumont, M.D., who was attached to the military reservation on Mackinac Island, had an opportunity presented to him. Like so many historic physicians, he finally took advantage of a chance to write his name in lasting medical history.

For many years our medical people in Michigan had contemplated preserving this memorial. The project has now been accomplished and enduring preservation assured. The shrine will ultimately contain among the relics and equipment, a list of our members whose gifts made the restoration possible. We are sure those whose names are inscribed will feel pride in their accomplishment. The list is not yet closed.

This act of certain members of the Michigan State Medical Society may have precipitated a movement which could rival the restoration at Williamsburg. There is enough historical background in the Mackinac Island area to do so.

The efforts so far accomplished have now been officially recognized and made permanent. The Michigan Legislature, by joint resolution, has recognized this history-making gift to the people of Michigan.

STATE OF MICHIGAN
MICHIGAN LEGISLATURE

Senate Concurrent Resolution No. 34

Offered by Senators Perry W. Greene, Carlton H. Morris, Haskell L. Nichols, Lewis G. Christman, Frank Andrews and Creighton R. Coleman

(Representatives T. Jefferson Hoxie, Arnell Engstrom, Clayton Morrison and Harold Hungerford named co-sponsors)

A CONCURRENT RESOLUTION IN RECOGNITION OF THE GIFT OF THE BEAUMONT MEMORIAL ON MACKINAC ISLAND TO THE STATE OF MICHIGAN BY THE DOCTORS OF MEDICINE OF MICHIGAN ON JULY 17, 1954, SAID MEMORIAL HONORING A GREAT MEDICAL PIONEER, WILLIAM BEAUMONT, M.D., WHO BY HIS MEDICAL FINDINGS MADE A NOTEWORTHY CONTRIBUTION TO MICHIGAN AND TO THE UNITED STATES OF AMERICA.

WHEREAS, On Mackinac Island in the retail store of the American Fur Trading Company, on June 6, 1822, Alexis St. Martin, a French-Canadian voyageur, suffered an accidental gun shot wound which was immediately treated, but which left a permanent opening into his stomach through which William Beaumont, M.D., was able to study stomach physiology; and

WHEREAS, Dr. Beaumont made scientific report of his findings revealing the chemical nature of the digestive processes, thereby laying the foundation of our knowledge of digestion; and

WHEREAS, The findings of Dr. Beaumont have contributed to the welfare of humanity and have been acknowledged by the medical profession and the world of science; and

WHEREAS, The Michigan State Medical Society in recognition of Dr. Beaumont—who was an honorary member of the Michigan Territorial Medical Society,, forerunner of the Michigan State Medical Society—organized, financed by voluntary contributions of its membership, and successfully culminated the project of restoring the American Fur Trading Post on Mackinac Island and presented it to the people of Michigan; and

WHEREAS, This Memorial was accepted on July 17, 1954, by the Mackinac Island Park Commission en toto and in the person of W. F. Doyle, Resident Commissioner, who, himself, was a stimulating force in the development of this Memorial; now therefore be it

RESOLVED BY THE SENATE (the House of Representatives concurring), That the members of the Michigan Legislature welcome this opportunity to recognize the contribution to the health and welfare of mankind made by Dr. William Beaumont, Michigan's greatest medical pioneer, and expresses its appreciation to the doctors of medicine of Michigan in the form of their representative organization, the Michigan State Medical Society, for this most appropriate gift to the people of our state; and be it further

RESOLVED, That a copy of this resolution be transmitted to the Michigan State Medical Society; to Dr. Otto O. Beck, Chairman of the Beaumont Memorial Committee; to W. F. Doyle: and to the surviving members of Dr. Beaumont's family.

Adopted by the Senate, March 17, 1955.
Adopted by the House, March 17, 1955.

NORMAN E. PHILLEO
Clerk of the House of Representatives.

FRED I. CHASE
Secretary of the Senate.

INTESTINAL OBSTRUCTION AFTER GASTRIC SURGERY

(Continued from Page 676)

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Grace Hospital

Medicine's Unsolved Problem

By Robert L. Novy, M.D.

President of Michigan Medical Service

THE American people have had a good taste of voluntary prepayment and what they are saying about it is unmistakable. They like it. The way they have taken to it has already exploded one of the pet early theories, that prepayment is primarily a device for serving the needs of the low income groups. Everybody wants prepayment. Michigan's Blue Cross and Blue Shield Plans today cover members of the State Bar Association and the Farm Bureau, top-bracket auto executives and assembly line workers, millionaires and dime-store clerks. Nation-wide it is estimated that 98 million people have some kind of surgical coverage and more than 100 million are covered for hospital expense.

Government medicine is no longer an imminent threat, but it must be added in the same breath that voluntary prepayment is no longer a defense mechanism. It has become a popular phenomenon on its own, a mighty big American reality, shaped by events in every phase of our lives and felt everywhere. A. L. Kirkpatrick, manager of the U. S. Chamber of Commerce insurance department, reported in the December, 1954, issue of *American Social Security* that "About 900 insurance companies, in addition to all of the other various mechanisms, are now engaged in writing some of the health insurance coverages. The premiums paid for health insurance now exceed $3 billion annually and the assets of the insurers run into many billions of dollars."

Outstrips Automobile Insurance

"We are accustomed," Kirkpatrick continues, "to think of the automobile industry as an outstanding example of the miracle of modern industrial development. But the growth of health insurance has outstripped the growth of automobile insurance both in volume and premiums, in its rate of growth and in the number and aggregate size of the insurers engaged in writing this protection."

Let me admit that these facts astonish me, even stagger me a little, although I am now in the middle of my thirteenth consecutive year as President of Michigan Medical Service and have seen the membership of the medically controlled plans grow from less than a million to their present 32,000,000.

Looking back to 1942, when the life of Michigan Medical Service hung very much in the balance, and the commercial carriers were waiting for us doctors, in all our innocence, to do the pioneering work in this strange new field, my pride in what has been accomplished is no greater than my astonishment.

"This development of modern health and accident insurance," Kirkpatrick comments in the same article, "is the outcome of voluntary efforts in the best tradition of the American private enterprise system. It has not resulted from government sponsorship or compulsion."

The Unsolved Problem

We doctors can be justly proud of the part we have played in this epic achievement. Yet one problem among many stands out in alarming relief. It is the problem of inadequate coverage. We know what inadequate coverage may mean in disappointment to the patient, in possible hardship, the worse because unexpected, for him and his family. We know how it can embitter physician-patient relations, and how it is doing precisely that each day of the week. To have 98 million people covered for surgical expense is an achievement, to be sure. But the fact is that the coverage of millions of these people is inadequate, and that in too many millions of cases it is pathetically inadequate.

What is particularly bad is that the coverages

provided by many of our Blue Shield Plans are as inadequate and unrealistic as those of a large number of our commercial carriers.

Our business is patients, not quantitative statistics. Our measure of the job must be what it is doing for the individual who is our patient. Let us look at him. Can we expect the average lay citizen to know whether the coverage he is buying will prove adequate when he comes to use it? The answer being obvious, are we doing our job?

Leaving it to the People

Can we honestly expect the commercial carriers to do business in any other way than by taking the path of least resistance? The path of least resistance is simply selling the people what they think they want. And how are the people to know what they want from our extremely complex profession if we are silent? Or worse, if we allow our own plans to offer coverages that have little relationship to the realities of the cost of today's medical and surgical services?

There are those among us who are very much disturbed because the commercial carriers in the past five years have run circles around the Blue Shield Plans in the matter of enrollment. I for one am not too worried about this development. I see no compelling necessity for Blue Shield to worst the commercial carriers in competition. To me, as a practicing physician, Blue Shield is essentially the instrument through which I can hope to establish realistic and professionally responsive standards in medical coverage, and make them felt competitively.

Role of Blue Shield

Organized medicine in the U. S. has a formidable instrument in Blue Shield for maintaining the balance of control in the surgical-medical prepayment field, for influencing the competitive quality and scope of all of the coverages, and for providing the people with an honest, objective and professionally realistic standard of coverage.

This is the role I see for Blue Shield. I have no desire to see it become a monopoly. I want it to serve primarily as a powerful catalyst in the growth and development of prepayment. But this is not the role Blue Shield is playing now. We doctors have become complacent, and under the influence of our complacency so many of the Blue Shield Plans have become tight little clubs of local smugness. Where the Blue Shield Plans should be catalysts, they show only stagnation.

A Few Shortcomings

Some of our Blue Shield Plans reflect this stagnation in four characteristic ways:

- By refusing to increase benefits.
- By an increasing indifference to the principle of service benefits.
- By meeting all national challenges with a chip-shouldered leave-me-alone attitude.
- By a fond preoccupation with quantitative statistics.

Nor is it easy to expose and cope with these shortcomings, for their roots go back, unfortunately, to the very beginnings of Blue Shield.

The Blue Shield Plans were established in the main because the doctors, subjected to various pressures, came to realize that they had to offer a voluntary program of prepaid medical care or face the alternative of government medicine. To most of the doctors it was a reluctant choice between two evils. They turned to Blue Shield as the lesser of the two, as simply the necessary evil. Here in Michigan, where the effort to establish a prepaid medical plan caused considerable dissension in the ranks of the doctors, the division was between those who saw the hard unpleasant necessity for the effort and those who saw it only as folly. None was enthusiastic.

Necessary Evil

This concept of Blue Shield as a necessary evil has persisted to this day. The first years of Blue Shield brought their inevitable troubles. Learning by the trial and error method proved a painful experience, in some cases embarrassing to the medical profession. Some of the unhappy results brought on a mood of stubborn caution.

When things eased up a bit, and the plans began to grow and gain strength, the doctors relaxed in a defensive sort of a way, but the mood of caution remained, as did the concept of the necessary evil.

Today it is obvious that prepayment is the shape of the medical economics of the future. Moreover, this future is traveling toward us in seven-league boots. Voluntary prepayment is offering the American people and the medical profession unlimited opportunities for financing the nation's health needs on a scale never before imagined.

The New Challenge

Prepayment is no longer something for the doctors to sponsor or not to sponsor. It is here. As Kirkpatrick has pointed out, it is already a multi-billion dollar business, growing at a phenomenal rate even for an American phenomenon, with billions in reserve. Employers, labor unions, trade associations, farm organizations, are raising and putting aside more and more hundreds of millions of dollars each year to provide coverage for increasing millions of people, without so much as consulting the doctors. Independent plans, largely sponsored by labor unions that represent the extreme left wing of opposition to organized medicine, already provide surgical and medical coverage for more than five million people.

This is prepayment 1955. It is time that we doctors abandoned the attitudes of the 1930's and 1940's. It is imperative that the medical profession step in vigorously in today's prepayment developments to make its influence felt. This we will be unable to do until we bury once and for all the antiquated concept of Blue Shield as a necessary evil.

Developments in the prepayment field have already moved dangerously away from the necessary influences of the medical profession. It would be nothing but folly on our part to continue nursing our complacency and smugness while the billions in premiums and reserves build up a power beyond our control.

Looking Ahead

The medical profession needs a program:

1. We must set for ourselves the clear objective of getting the balance of control in the surgical-medical prepayment field into the hands of the medically controlled plans, and achieving this end through the development of quality coverages of the highest professional standard.

2. We must completely reappraise our attitude toward the Blue Shield Plans, and recognize them for what they are—our only effective means for making the professional view and professional standards felt on the competitive market.

3. We must stop bemusing ourselves with quantitative statistics and get our thinking in line with the realities of the situation.

The prepayment movement has assumed a decided national pattern. It is on the national enrollment front that we are weakest, too, and primarily because of the local smugness of so many of our Blue Shield Plans. Our large manufacturing and transportation industries, our chain stores and the many other nation-wide enterprises, are tending more and more to cover their employees with national contracts. Also within the labor unions enrollment decisions and enrollment planning have tended to move more and more to the level of the internationals.

The Major Handicaps

The following are the major handicaps that have hamstrung the Blue Shield Plans, and which one must add they can scarcely hope to overcome without the positive backing of the medical profession:

A. Too few of the Blue Shield Plans are real service plans. Management and labor see only the disadvantages in negotiating contracts on the national level with a dozen different indemnity plans—although they call themselves Blue Shield—when a commercial carrier can do the whole job with a single indemnity contract.

There is no getting away from the fact that to management and labor union officials, as well as to the average citizen, real service benefits are the distinguishing mark of the medically controlled plans and spell out the advantages of professional sponsorship. Nor have the doctors any other way of imposing professional standards on their coverages than by underwriting services rather than dollars.

A Blue Shield Plan that is not a real service plan turns out to be neither fish nor fowl in the national enrollment picture.

B. The Blue Shield Plans that offer service benefits are still too addicted to unrealistic income limits, which in too many cases destroy the advantages offered by the service benefits.

C. Unlike the Blue Cross Plans, the Blue Shield Plans have not as yet developed the necessary national mechanics for working out uniform benefits for the national accounts that desire them.

National accounts generally want uniform benefits for all of their employees. The unions are even more disinclined than management to offer their members a motley of benefits, differing from state to state, often from city to city.

It is not my suggestion that the Blue Shield Plans should all adopt uniform fee schedules and uniform rates for their total operations. Nothing

in my estimation would be more unrealistic. What is proposed is that the Blue Shield Plans adjust themselves to the necessities of cooperating with other plans in the development of programs for national accounts that call for uniform benefits.

Need for Action

If the medical profession will take the necessary steps to eliminate the three handicaps I have described the Blue Shield Plans will then find themselves in a position of influence in the national enrollment area, that is the area in which our economy is making its major adjustments to prepayment. Unless this is done, unless we make it possible for the Blue Shield Plans to strike a practical balance between their responsibilities to their local communities and their function in serving the needs of the national economy, it is very much my fear that most of them will shortly become mere anachronisms.

Should the latter happen, organized medicine will suffer what may well turn out to be a disastrous defeat. The distinguishing mark of American medicine is the almost undivided responsibility the profession has in determining the standards and the direction of its own practice. This has been the source of its dynamics and its vitality, from which the people have derived such large benefits. It is this tradition of undivided responsibility that is now at stake.

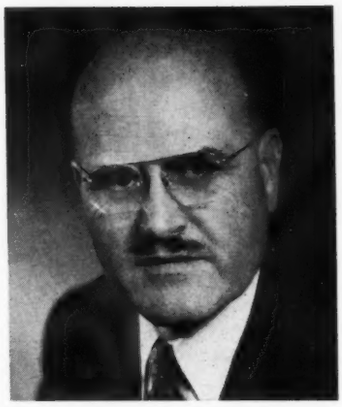
It is at stake because unless organized medicine can now reveal the vigor and vision to extend its concept of professional responsibility into the prepayment field, it faces the real danger of becoming the pawn of those who control the rapidly accumulating billions going into prepayment. We doctors cannot regulate prepayment through legislation, for that would be compounding the danger. We cannot hope to influence it with professional advice. Under our system we can be an influence to be reckoned with only if we make our ideas and our standards competitively significant in the process that is shaping medical prepayment.

Power is not my thesis, but professional realism before this tremendously important new social development. It would be a social tragedy if in this hour, when the American people are spending increasing billions to secure for themselves the benefits of our services, that they were to be left to build their prepayment program in a medical vacuum.

This is what is beginning to happen and unless we doctors rid ourselves of our 1930 preconceptions and our 1940 attitudes, this may well happen with a swift and irreversible finality.

FORMER MICHIGAN HOSPITAL SERVICE EMPLOYES NOW WITH OTHER BLUE CROSS SERVICES

Name	*Hired*	*Left MHS*	*Present Position*
Block, L. F.	5-16-50 PT	1-22-54	Manager, Public Relations Division, Blue Cross-Blue Shield Commissions, Chicago, Illinois
Mody, R. W.	10-22-45	8-29-52	Assistant Director, Blue Cross Commission, Chicago, Illinois
Cheney, Jean (Mrs.)	11-11-46	7-24-53	Statistician. United Medical Service (Blue Shield) New York
Jensen, M. L.	4-14-49	7-31-53	Sales Service Health Service, Inc., and (BC) Medical Indemnity of America, Inc. (BS) Chicago, Illinois
Cavanaugh, W. H.	10-15-51	7-24-53	Hospital Council of Southern California, Los Angeles, California
Cruse, W. H.	1-16-47	4-23-53	Hospital Accounting Consultant (BC) Oakland, California
Hersey, L. G.	7-13-39	9- 1-49	Executive Director, Blue Cross-Blue Shield, Salt Lake City, Utah
Kruger, E. O.	10- 1-46	6-23-54	Hospital Council of Southern California, Los Angeles, California
Mannix, John R.	2-15-39	6-30-44	Director of Blue Cross, Cleveland, Ohio
Ramige, G. W.	10-15-41	7-15-44	Comptroller, Blue Cross, Indianapolis, Indiana
Skelley, W. R.	7- 9-46	1-28-49	Comptroller, Blue Cross, Denver, Colorado
Brown, James C.	1-28-46	1-15-49	Actuary, Blue Cross District XI, serving Los Angeles, Portland, Oakland, Seattle, Boise and Salt Lake City.



Nationalism versus Provincialism

By Lewis G. Hersey
Salt Lake City, Utah

Actually, I was asked to speak on "Nationalism," however, I am inclined to believe that a paper solely on Nationalism without some discussion of provincialism with respect to our mutually common problem would be amiss on the 21st day of March, 1955, which can well go down in the history of Blue Cross and Blue Shield Plans as the day of decision.

In fairness to all of us in attendance at this meeting, whether we be Directors of Plans, elected officers of Plans, Trustees or Directors of Boards or just interested hospital administrators or practicing physicians, perhaps we should draw our ground rules with respect to a definition of our subject. According to Webster, Nationalism may be defined to be "devotion to, or advocacy of, national interests or national unity." In contrast with that definition of Nationalism, Webster has this to say about Provincialism, namely, "that which is characteristic of a province, a certain narrowness, illiberality, or lack of polish or enlightment—a district remote from the mother country or from the metropolis." After hearing the definition of Provincialism, I am sure that most of you must realize why someone from the State of Utah was asked to speak on this subject.

Utah is one of the newer states in the Union, reaching statehood in 1896—only fifty-eight years old; one of an area of 84,916 square miles with a population of 730,000—less than ten persons per square mile. With this situation, we should have some provincial characteristics and we are frank to admit our Blue Cross-Blue Shield philosophy in the past was most provincial—but today we do have a national viewpoint with respect to Blue Cross and Blue Shield.

Keeping these two differences in mind, I should like to review from my own memory and experience certain highlights or mileposts in the growth of this great, much copied movement. There are some in this room that can well remember in the beginning of their particular Plan, be it Blue Cross or Blue Shield, that it was definitely the leader in their particular area. Why was it a leader? Because it had a new philosophy which had tremendous public appeal. For the first time in many areas, prepaid coverage through your Plan was providing equal benefits for the spouse and eligible dependent children. Insurance companies prior to the birth of your Plan were only interested in the employed male because that risk provided the insurance company with a guaranteed margin of profit. Your Plan also probably covered children from birth, a complete innovation to later insurance company practice which perhaps covered children after ninety days of age, possibly after thirty days of age. Most Blue Cross Plans started with the magic number 21 as the limit of number of days. There was no magic about it, but it was a known fact that 98 per cent of all hospital cases never went beyond twenty-one days. For the first time, Blue Cross offered service benefits—such as they were, instead of a limited number of dollars toward the ancillary services necessary in hospital care. Blue Shield also offered service benefits for surgical procedures—an unheard of approach except for those comparatively few people in the country who may have enjoyed service benefits offered or maybe one or two doctors under contract by their employer. Blue Shield, therefore, offered free choice of physician, enhancing the inherent pride of every American to choose his own doctor and thus also protecting the private practice of medicine. Enough for the basic difference in philosophy—service as against cash indemnity. Unfortunately, a few Blue Cross Plans had too many initial contract benefits on a restricted service or on an indemnity basis, most of which have been changed.

Similarly, and for what reason I'll never know, certain medically sponsored Plans did not establish a Blue Shield Plan as we know it, on a service-benefit basis, but merely set up an insurance company on a limited indemnity basis. Why any group of doctors would ever go into the insurance business in competition with one of the biggest over-all industries in the world, I'll never know, because it offered nothing new aside from perhaps equal cash allowances for dependents and the privilege of continuation of the coverage when the subscriber left his place of employment, in addition to making payment directly to the doctor. The foregoing definitely falls into the category of provincialism, or perhaps you would rather I would say local autonomy. For a number of years, this method of operation

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Mr. Hersey, Executive Director of Blue Cross-Blue Shield in Utah, was formerly associated with Blue Cross-Blue Shield in Michigan.

Presented at the Annual Conference of Blue Cross-Blue Shield Plans, Chicago, Illinois, March 21, 1955

prospered; more people were served and the great American public was awakened to the fact that prepaid hospital and professional care was here to stay. The great telephone industry had its beginning in much the same manner. Years ago, I dare say, there were hundreds of local telephone companies in this country, each with varying equipment, varying rates and with varying limits as to the service afforded their subscribing customers. With the development of new equipment, however, what used to be a marvelous thing of being able to talk to another person across town became common place when it was possible to talk to persons hundreds, yes, even thousands of miles away. For the telephone industry to accomplish this amazing feat was not an easy one. There had to be standardization and there had to be uniformity of certain types of equipment, and there had to be much giving and taking on the part of undividual telephone companies, and had that not occurred, today the telephone on your desk would be a very limited means of communication in this modern world.

In the development of Blue Cross and Blue Shield, generally speaking, Blue Cross was the first Plan in a given community primarily because it was much easier to organize a small group of hospital administrators who served a large number of the public than it was to organize the number of doctors serving that same number of the general public. Again, hospitals had a number of common problems whereas physicians traditionally have successfully maintained a position of definite independence. Therefore, the hospital Plan was started and it was soon found that a surgical Plan was needed to better serve the community and for Blue Cross to grow, so that in most areas, Blue Cross preceded Blue Shield. The notable exception to this was in the Pacific Northwest where for years large and small timber companies had owned a hospital and had engaged the services of a physician to provide the necessary treatment for the employe. In most instances this eventually was extended to cover the employe's dependents. After a number of years, the doctors so engaged in such practice found that the employer was dictating, not only the doctor's practice, but his fees or income as well. The doctors took the position that they could be of more service to the community and have more freedom in their profession if they themselves set up the plan for prepayment, allowing the same timber companies and others to pay a fixed fee in order to provide their services to the subscribers, so that in this area the doctor-sponsored plans preceded the formation of Blue Cross or hospital service plans as we know them today.

While in this area of the country I would be remiss if I did not point out to the representatives of Plans from other areas that while the multiplicity of medical bureaus in Washington and Oregon may sound like provincialism, these same plans have recently established a pattern which all Blue Shield Plans should consider as a workable solution toward nationalism in this business. For example: one of our subscribers is out of our area—but is in Oregon. He requires the services of an Oregon doctor, who never heard of our Plan, but who is quite familiar with the Oregon Physicians' Service. The doctor reports the case to Oregon Physicians' Service. They in turn advise our office of the case and at the same time advise us what fee they would normally pay for the service. We confirm liability and forward our check to OPS for delivery to their participating physician in an amount their physician is accustomed to receiving for similar services. Why do this? It is a start toward making a service Plan—one of real service—despite limits of state or area boundaries. It is good for the doctor—and good for the subscriber—and automatically buys good public relations at no additional cost. What can be done in this area I believe can be worked out on a nationwide basis if—Blue Shield can be truly a service Plan—rather than cash indemnity.

As Blue Cross and Blue Shield Plans were started in many areas, the services of both Plans were merchandised to Johnny Q Public as one program, or at least as two companion programs. In some areas there are two governing Boards, one for each side of the program, each having their own Executive Director. In other areas, two Plans each with a governing Board, will have but one Executive Director, and there are areas where there are two Plans, but one Board, with one Executive Director. In some areas the two Plans operate entirely independently from the standpoint of relationship to each other, but each sells its services to a common prospect. Finally, we have those areas where the doctors' plan sells doctors' services on a service basis and hospital benefits on an indemnity basis. In the same area, the Blue Cross Plan sells hospital services on a service basis and professional services on an indemnity basis. In these same areas, these two Plans are competing with one another—ultimately confusing the public in many instances. The prime shadow that has fallen across our path of progress nationally with respect to joint operation has been the unfortunate human equation which permitted a difference in personalities to blossom to a difference in philosophy to the point that a Blue Shield and a Blue Cross Plan decided to go their own separate ways. I need not comment on the areas where this has occurred; however, I say without fear of contradiction, that everyone lost by reason of it, most importantly, the public, and secondly, each individual Plan so involved, and finally all other Plans, the degree of harm depending upon the proximity of your Plan to the scene of the fire. It breeds many questions, not only in the minds of subscribers—but creates suspicion with potential groups. Think not for one minute that commercial insurance

companies did not capitalize on such situations—brought about by tragic short-sighted thinking. If you doubt this, get the figures—and they will speak for themselves. Blue Cross-Blue Shield lost—and the commercial insurance companies gained. Fortunately this situation was provincial rather than national. The foregoing is not news to many people in this room, but in my opinion is necessary to provide part of our stage setting in this hour of decision.

After a few years of operation it became quite evident that our future growth in the field of service to more people was definitely limited as we could not provide a common denominator for those national accounts, which in this business is uniformity of coverage although not necessarily uniformity of rates—rates are academic. The executives of national accounts—and labor unions, national in scope, have no concern for the limited area served by each of our Plans. Let's take something tangible such as an automobile. Can you imagine for one minute the purchasing agent of Proctor and Gamble wanting to place a fleet order with one of the major automobile manufacturers for a specified type of panel truck to be painted black and white, with a V-8 type engine, automatic transmission, taxicab-type springs, and tires of a specific size. Then imagine the automobile manufacturer in discussing the potential order tells Proctor and Gamble that for sake of economy they will be glad to make delivery from eight assembly plants throughout the country, but that in California they have no black or white paint, so the panel trucks will be painted red; that from Atlanta assembly plant the cars will be delivered with a straight 6 cylinder motor—in Kansas City the cars will have standard transmissions, in Seattle, standard springs and in Utah there is a real problem—there the cars will be delivered with no tires at all—Gentlemen—right there is where the "nuts came off the buggy." I am sure that the purchasing agent of Proctor and Gamble would quickly seek a new supplier for a thousand automobiles. The buyer in this instance wants uniformity—he has to keep cost figures—he wants uniformity of equipment for a given job. He is the buyer—and as such is in the position to dictate the specifications of the product he is interested in purchasing. In this business of ours many national employers and nationwide unions not only seek, but demand uniformity of coverage for their personnel whether they are located in New York, Chicago, or the Pacific coast, and I need not mention one example—for you each have one of your own. We established a vehicle to provide such potential groups with this uniformity known as Health Service and Medical Indemnity, and while on the hospital side of the picture such uniformity can be offered, but on the professional side we fall quite short of being able to do the job as well—because it is indemnity—and a number of Blue Shield Plans are unable or unwilling to "take off" such underwriting in their areas. With limited capital and surplus—our vehicle is brought almost to a standstill.

At this point, at the risk of being severely censured, I wish to express an opinion for what it is worth. Some may think it is idealistic and that it will only be possible with the millennium. Others will believe it is not necessary, but I wish to take the position that it is necessary and **can** and **must be accomplished** if our great movement is to progress at the pace it well deserves. I maintain that no Blue Shield Plan has any reason for being in operation unless it is on a service basis. To operate otherwise is to merely mimic the insurance industry, be a "me too" business—instead of the leader. It is essential in the first place because the medical profession itself is the only means which can provide service benefits to the public, and Blue Shield is but an arm of the profession. Opponents to this idea, be they doctors of medicine, Board members, or Plan directors, must realize that there has to be a will to succeed in this matter or it never can come to pass. To make it possible for it to come to pass, doctors must be paid a realistic fee and not be asked to subsidize the Plan beyond the initial period of such transition. Service benefits are what the public wants, and, make no mistake, what the public wants it usually obtains. If we are not able to provide service benefits, I am sure that there are those in politics who could dream up a service benefit plan over which you or I or the practicing physician would have no voice or control. If this can be accomplished rapidly enough we will then have established a sufficient common denominator to be compatible with the common denominator on the Blue Cross side, such common denominator being available by uniform contracts, Health Service, or the well known syndicate. Obviously the fee schedules of the numerous Plans need not be identical, but should be acceptable to the medical profession in their particular community. Briefly, if all Blue Shield Plans could see this picture on the horizon of perhaps a dual program with a dual fee schedule and dual rates, one perhaps with a family income ceiling of $3,500.00 to $5,000.00, and the other with, say, $6,000.00 or $7,500.00, this, coupled with a broad Blue Cross base, would afford every national group with a program it would be difficult for them to avoid. Right now we in Utah even have an experimental group with a service income ceiling of $10,000.00. The public would be eager for it, organized labor would demand it, and the national employer would, I am sure, accept such a combined and wide service as unique. Sure, this idea is idealistic, but unless we make a determined effort to achieve this goal it will never be accomplished.

You will pardon this reference to our own situation. With all due respect to members of my two Boards in attendance here today, and like due respect to their predecessors, I am sure that they will

agree that the situation in Utah six years ago was definitely provincial in character. Why shouldn't the Boards have been provincial and thus, the Plans be provincial, when the words "local autonomy" were taken too literally—too often. Ladies and Gentlemen, we had our problem in Utah. We had one product to sell and it was a case of the buyer taking that one or he bought from someone else. Today we have a multiplicity of contracts and if an employer or labor group does not find the product that they want currently on our shelves, we make certain that we promptly develop a product which embraces the benefits he wants, at a realistic price, of course. I dare say that had I not lead with my chin with both my Boards, we today might still be writing one, or possibly two contracts and seeing a lot of business go elsewhere. Define the national common denominator on a service basis—and we will get aboard. Our rate of growth is not phenomenal, but it is sound and steady. Many other Plans have seen fit to become public conscious and have similarly developed several patterns for sale. They, too, can get aboard quickly. Unfortunately, there are other areas in which I am inclined to believe that the Executive Director has not taken a position of leadership with his Board telling them the facts of life about national accounts and thus we do not have as much uniformity available for national accounts. Far be it for me to suggest that each Plan rewrite all of their local business under a uniform type of national contract, but I do say that every Plan should have a contract available that will meet the requirement for sale nationally. I know of no manufacturer today who is making but one product who would not be willing to vary the product sufficiently if such a modified product could be sold to buyers he at present cannot reach. If there be such manufacturers, I must state that they are provincial in nature.

I am sure that there are many in this room who have attended previous national conferences or especially called national meetings to meet a situation of a national account. At such meetings a poll is taken to determine whether or not individual Plans can comply or accede to modifications necessary to make the national account work. Much lip service is given. There are precious few negative positions indicated, but when the chips are down, it is found that there are big holes in the national pattern so that the national account loses interest in Blue Cross-Blue Shield in favor of a carrier which is not confronted with provincialism and short thinking. I am inclined to believe that individual Boards of Directors or Trustees and Members of State Medical Associations could be sold the virtues and advantages that will inure to them individually and to the profession at large by adopting the service principle. Little did I think in 1940 or '41 when I was given the opportunity to attend a national meeting of Blue Cross in Chicago at the Palmer House on this very subject when the crux of the problem at that time was uniformity of benefits, uniformity of rate being purely a secondary and academic question, that some 15 years later I would find myself addressing a similar gathering with the problem more acute and still yet unsolved—so it is not new. It must be solved at this Conference. Surely no one in this room, including myself, has any idea of destroying local autonomy of any Blue Cross-Blue Shield Plan, but there are many of us in this room, I am sure, who feel that local autonomy must be amended sufficiently to provide ways and means of offering our service collectively to national accounts. I need not repeat why the non-operating employes of the major railroads did not choose Blue Cross and Blue Shield. Obviously, there was no single reason why, but there were some reasons which could have been avoided or at least lessened by some giving and taking on the part of Blue Shield and Blue Cross Plans.

My hat is off to those many persons on the so-called task force who worked their hearts out in this particular instance and in many other instances only to find that what they wanted to sell and could have sold, just was not available. I ask you, Ladies and Gentlemen, is this progress or is this stagnation? Is it nationalism or provincialism? While I have a number of friends with General Motors and with Ford Motor Company, I am sure they will forgive me for what I am about to say, but it is apropos to our situation. Ford Motor Company led the field for many years then Chevrolet took first position for another number of years. Each of you read recently where Ford Motor outsold Chevrolet. Was that an easy task? I know nothing about the manufacture or sale of automobiles but I will guarantee you that every person on the Ford payroll had that objective in mind, and now the shoe will be on the other foot—watch Chevrolet next year. In our business we were once the leaders where we rightfully belong. Are we to regain that leadership, or are we to die on the vine? Discussion in the bar or in your individual suites will not produce the type of program necessary to do the job, but you Executive Directors and you Board members must return to your respective Boards and shake off any ideas of false security under which your Plan may be laboring, namely, that what you are presently offering is good enough for national accounts. Personalities, in my opinion, have no place in this business when they stand in the way of progress, and for my own Board members here, that goes for Utah as well. This movement is bigger than any individual or small group of individuals. The movement in general was born of necessity. It has prospered; it has become a household byword and, Ladies and Gentlemen, we would be derelict in our duty to the American people, the American Medical Association and the American hospital system if we allow anything to stand in the path of progress. You have all heard the quotation or motto, "the diffi-

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John W. Castellucci Assumes New Duties

John W. Castellucci, well known to doctors throughout Michigan as Assistant Director of Michigan Medical Service in charge of Professional Relations, has assumed his duties as Executive Director of the Blue Shield Commission in Chicago.

Castellucci's twelve years of vigorous association with Michigan Medical Service were marked by his complete understanding of doctors' problems, and his constant recognition that Blue Shield progress depended on its originators, the doctors.

As the energetic force which brought interpretation of Blue Shield to every doctor in Michigan through the MMS Professional Relations Department, Castellucci also was one of those responsible for the Michigan Veteran's Home-Town Care Plan, which set the pace and pattern for service-connected veterans care for the entire country.

Castellucci joined Michigan Medical Service in 1943 and was assigned to the Claims Department. He soon saw that much of the difficulty of processing doctors' reports could be eliminated if all the doctors thoroughly understood Blue Shield, their own Plan.

It was then that the Professional Relations Department was expanded. Doctors were contacted individually for their ideas, as well as for their further understanding of Blue Shield procedure. From these personal interviews came helpful information which Blue Shield absorbed to alter, simplify and modify procedures necessary to carry out the Plan to offer the greatest benefit to doctors and subscribers.

Just as the Professional Relations program began to gain ground another related problem developed in 1945. Veterans of World War II were returning to their homes, many of them with service-connected disabilities. The veterans wanted care from their own family doctors and the Michigan State Medical Society and Blue Shield wanted to serve them. From this need of the veterans and determination of Michigan doctors evolved the Michigan Veterans Care Plan, winning approval from the Veterans Administration as the most logical method presented to handle the tremendous problem.

Castellucci, a member of the committee which went to Washington to present the Michigan Veterans Plan, had the task of reducing to a minimum the required government paperwork and red tape. He not only succeeded in reducing the forms which doctors had been required to fill out from eight pages to one, but pushed the simplified form through for approval by the Veterans Administration.

With the Veterans Plan underway, Castellucci returned to his Professional Relations work, only to be called to the Blue Shield Commission in Chicago in 1947 as an Assistant Director, dividing his time between Commission duties and Michigan Medical Service. This added task, however, was an extension of his Professional Relations work, since its success in Michigan had brought interested queries from other Blue Shield Plans across the country.

Castellucci continued his work in Michigan with the Veterans Care program and Professional Relations, however, while he traveled extensively explaining the MMS Professional Relations program to other Blue Shield Plans. The result was that many Plans adopted the Professional Relations procedure as developed in Michigan, and Castellucci's manual for Professional Relations soon became a nation-wide guide for Blue Shield.

Castellucci returned to Michigan Medical Service on a full-time basis in July, 1951 to expand the work of the Professional Relations program, which had developed from a one-man operation to one requiring 12 field representatives covering the entire state.

Born in Boston in 1906, Castellucci spent his earliest childhood in Portland, Maine, moving with his family to Detroit when he was of high school age. Prior to that time, he had won a musical scholarship to Manlius Military Academy near Syracuse, N. Y., and upon his arrival in Detroit began playing professionally while a student at Eastern High School. An accomplished violinist, he also played guitar, banjo and French horn with orchestras in Detroit.

Entering pre-medical school at College of City of Detroit (now Wayne University) in 1925, he decided after two years to travel abroad. He spent a year in Paris, returning to the University of Detroit to help produce the school's first musical. He then decided to study law at Detroit College of Law.

He had already been working since 1931 for the City of Detroit as special investigator of fraud cases for the Hospital Investigation Bureau, and, since two brothers were lawyers, he never practiced law. But, he could not stay away from music. He organized and directed an 85 piece

symphony orchestra for the American Legion Washington Post and directed the Highland Park Symphony for two seasons.

In his spare time he set up a summer music camp near Pontiac, raising money, borrowing Detroit Street Railway buses, Army tents and even an Army cook to give 80 children a musical vacation for two summers.

Shortly after Pearl Harbor, Castellucci volunteered for the Army. He was injured during his officer candidate training and was discharged in June, 1943 with the rank of corporal. Two months later he joined Blue Shield.

As Castellucci has contributed his knowledge and experience gained with Michigan Medical Service to other Plans across the country, several other MMS associates have also left Michigan to service Blue Shield elsewhere. Among them are Charles H. Coghlan, Kenneth E. Trim, Lynn A. Doctor and Leonard J. Raider, M.D.

Charles Coghlan is now Executive Vice-President of Ohio Medical Indemnity (Ohio Blue Shield), having served with Michigan Medical Service from 1940 to 1945, first as a claims examiner and later as Manager of the Professional Relations Department. Currently, he is also a member of the Blue Shield Commission and is Resident Vice-President of Medical Indemnity of America.

Kenneth Trim, now Assistant Executive Director of Blue Cross-Blue Shield of Alabama, joined the Professional Relations Department of MMS in January, 1946, serving the southwestern part of Michigan, with headquarters in Grand Rapids. Prior to that time he spent four years as a District Manager at Battle Creek for Michigan Blue Cross. He left Michigan Medical Service in October, 1950 to co-ordinate the physicians relations program for the Blue Shield Commission.

Lynn Doctor, who joined Michigan Medical Service in December, 1945 as statistician, left MMS in February, 1948 to serve in the same capacity with the Blue Shield Commission. He is now Vice-President in charge of Statistics and Underwriting for United Medical Services, Inc. (Blue Shield), of New York, serving seventeen counties, including New York City.

Dr. Leonard Raider joined Michigan Medical Service as Assistant Medical Director in 1949 when he was discharged from the U. S. Navy Medical Corps. He left MMS in 1950 to become Chief Medical Claims Examiner of United Medical Services, Inc. (Blue Shield), of New York, where he is now Vice-President in charge of Claims and Professional Relations.

NATIONALISM VS. PROVINCIALISM

(Continued from Page 714)

cult we do right away; the impossible takes us a little longer." I ask you, now that the difficult is a reality, are we not this very moment facing the impossible? Maybe the obstacle in your area is one of a legal nature; maybe it is an ingrown philosophy that must be changed. Maybe it is Plan management. Whatever it may be, every one of us here must accept the challenge and hasten the solution in this hour of decision.

In conclusion, I repeat the definition of nationalism, "devotion to, or advocacy of, national interests of national unity," and I implore each of you to determine here and now that you will take the necessary steps with your governing Boards to at least provide the necessary common denominator to make national enrollment a reality instead of the ever present insurmountable problem that it is, with what we have to offer today.

HIGHLIGHTS OF THE COUNCIL

(Continued from Page 644)

waukee, February 24-26, was received with thanks and referred to Editor Haughey for insertion in JMSMS.

- **G. B. Saltonstall, M.D.,** Charlevoix, was appointed as MSMS representative to attend the Annual Session of the State Medical Society of Wisconsin, Milwaukee, May 3, 4 and 5; Ralph W. Shook, M.D., Kalamazoo, was appointed as official representative to the Georgia State Medical Association Annual Session, May 3, 4 and 5.
- **Legal Counsel J. Joseph Herbert** reported on several matters including (a) suit of Wm. A. Kopprasch, M.D., vs. MSMS et al, (b) preservation of books in the Beaumont Memorial through help of the University of Michigan; (c) privilege communication status of physicians' records; (d) on a number of legislative bills now in the Michigan Legislature of interest to the medical profession.
- **J. S. DeTar, M.D.,** Milan, was congratulated on being chosen as President Elect of the American Academy of General Practice March 30 in Los Angeles.

TIMES HAVE CHANGED

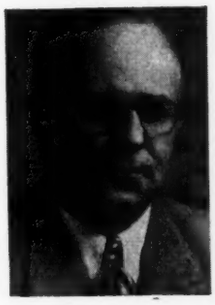
A speaker reported, "An encyclopedia published in 1878 had five lines on 'atom' and five pages on 'love.' One of the latest encyclopedias published in 1954 had five pages on 'atom' and nothing on 'love.' Does this explain 'cold war' or 'peaceful co-existance'?"

Michigan State Medical Society

The Ninetieth Annual Session

WILLIAM BROMME, M.D.
Detroit
Council Chairman

R. H. BAKER, M.D.
Pontiac
President



J. E. LIVESAY, M.D.
Flint
Speaker

L. FERNALD FOSTER, M.D.
Bay City
Secretary

OFFICIAL CALL

The Michigan State Medical Society will convene in Annual Session in Grand Rapids, Michigan, September 26-27-28-29-30, 1955. The provisions of the Constitution and By-Laws and the Official Program will govern the deliberations.

R. H. BAKER, M.D.
President
WILLIAM BROMME, M.D.
Council Chairman
J. E. LIVESAY, M.D.
Speaker
K. H. JOHNSON, M.D.
Vice Speaker

Attest:
L. FERNALD FOSTER, M.D.
Secretary

K. H. JOHNSON, M.D.
Lansing
Vice Speaker

TWO-DAY SESSION OF HOUSE OF DELEGATES

September 26-27, 1955

The 1955 House of Delegates of the Michigan State Medical Society will hold a two-day session beginning Monday, September 26, at 10:00 a.m. The business of the House of Delegates will be transacted in the Grand Ball Room of the Pantlind Hotel, Grand Rapids.

The House will meet also on Monday at 2:00 p.m. and at 8:00 p.m. and on Tuesday, September 27, at 9:30 a.m. and at 8:00 p.m.

The intervals between meetings of the House of Delegates have been spaced to permit the Reference Committees ample time to transact all business referred to them.

SEATING OF DELEGATES

"Any Delegate-Elect not present to be seated at the hour of call of the first meeting may be replaced by the accredited Alternate next on the list as certified by the Secretary of the component County Society involved." —MSMS By-Laws, Chapter 8, Section 6.

OUTLINE OF 1955 ASSEMBLY AND SECTION SPEAKERS

90th Annual Session MSMS

Grand Rapids, September 28-29-30, 1955

Time	Wednesday September 28	Thursday September 29	Friday September 30
A.M. 8:30– 9:00	Registration Exhibits open	Registration Exhibits open	Registration Exhibits open
9:00– 9:30	*Surgery Panel* *Chairman* STANLEY O. HOERR, M.D., Cleveland	*Surgery* BARRY J. ANSON, Ph.D. Chicago, Ill.	*Gastroenterology-Proctology* (Beaumont Lecture) GARNET W. AULT, M.D. Washington, D. C.
9:30–10:00	Participants: R. RUSSELL BEST, M.D., Omaha, Neb.; RALPH COLP, M.D., N. Y. C.; and RICHARD H. LYONS, M.D., Syracuse, N. Y.	*Ophthalmology* HUGO L. BAIR, M.D. Rochester, Minn.	*Dermatology* RICHARD L. SUTTON, JR., M.D. Kansas City, Mo.
10:00–11:00	INTERMISSION TO VIEW EXHIBITS	INTERMISSION TO VIEW EXHIBITS	INTERMISSION TO VIEW EXHIBITS
11:00–11:30	*Industrial Surgery* RUSSELL S. FISHER, M.D. Baltimore, Md.	*Otolaryngology* JAMES B. COSTEN, M.D. St. Louis, Mo.	*Radiology* HAROLD W. JACOX, M.D. New York, N. Y.
11:30-12:00	*Urology* WILLIAM N. TAYLOR, M.D. Columbus, Ohio	*Nervous & Mental* FRANCIS J. BRACELAND, M.D. Hartford, Conn.	*Dermatology* ROBERT R. KIERLAND, M.D. Rochester, Minn.
12:00 noon	DISCUSSION CONFERENCE	DISCUSSION CONFERENCE	DISCUSSION CONFERENCE
P.M. 1:00– 2:00	LUNCH HOUR One Section Meeting 1:00–2:00 p.m.—luncheon *Urology* WILLIAM N. TAYLOR, M.D. Columbus, Ohio	LUNCH HOUR One Section Meeting 1:00–2:00 p.m.—luncheon *Otolaryngology* JAMES B. COSTEN, M.D. St. Louis, Missouri	LUNCH HOUR
2:00– 2:30	*Pediatrics* RALPH V. PLATOU, M.D. New Orleans, La.	*Obstetrics* SAMUEL A. COSGROVE, M.D. Jersey City, N. J.	*Anesthesiology* FREDERICK H. VAN BERGEN, M.D. Minneapolis, Minn.
2:30– 3:00	*General Practice* LEON S. MCGOOGAN, M.D. Omaha, Neb.	*Gynecology* RICHARD W. TELINDE, M.D. Baltimore, Md.	*Medicine* ARTHUR M. MASTER, M.D. New York, N. Y.
3:00– 4:00	INTERMISSION TO VIEW EXHIBITS	INTERMISSION TO VIEW EXHIBITS	3:00-3:30 FINAL INTERMISSION TO VIEW EXHIBITS
4:00– 4:30	*Obstetrics* WILLARD R. COOKE, M.D. Galveston, Texas	*Pediatrics* WALDO E. NELSON, M.D. Philadelphia, Pa.	3:30-4:00—*Medicine* OVID O. MEYER, M.D. Madison, Wisc.
4:30– 5:00	*Nervous & Mental Diseases* MAURICE LEVINE, M.D. Cincinnati, Ohio	*Public Health & Preventive Medicine* FRANKLIN H. TOP, M.D. Iowa City, Iowa	4:00-5:00 *Medical Symposium* A. CARLTON ERNSTENE, M.D. Cleveland, Ohio PENN G. SKILLERN, M.D. Cleveland, Ohio
5:00– 6:00	THREE SECTION MEETINGS	FIVE SECTION MEETINGS	FOUR SECTION MEETINGS
	Pediatrics RALPH V. PLATOU, M.D. New Orleans, La.	*Public Health & Preventive Medicine* FRANKLIN H. TOP, M.D. Iowa City, Iowa	*Dermatology & Syphilology* RICHARD L. SUTTON, JR., M.D. Kansas City, Mo.
	General Practice LEON S. MCGOOGAN, M.D. Omaha, Neb.	*Gastroenterology-Proctology* GARNET W. AULT, M.D. Washington, D. C.	*Medicine* OVID O. MEYER, M.D. Madison, Wisc.
	Surgery STANLEY O. HOERR, M.D. Cleveland, Ohio	*Ophthalmology* HUGO L. BAIR, M.D. Rochester, Minn.	*Anesthesiology* FREDERICK H. VAN BERGEN, M.D. Minneapolis, Minn.
	8:30–10:30 p.m. Officers' Night *Biddle Lecture* CHARLES L. ANSPACH, Ph.D. Mt. Pleasant, Mich.	*Obstetrics-Gynecology* SAMUEL A. COSGROVE, M.D. Jersey City, N. J.	*Radiology* HAROLD W. JACOX, M.D. New York, N. Y.
		Nervous & Mental FRANCIS J. BRACELAND, M.D. Hartford, Conn.	
		10:00 p.m. to 1:00 a.m. State Society Night MSMS Entertainment	END OF ASSEMBLY

Michigan State Medical Society

The Ninetieth Annual Session

PANTLIND HOTEL—CIVIC AUDITORIUM, GRAND RAPIDS
SEPTEMBER 26-30, 1955

INFORMATION

- **GRAND RAPIDS WILL BE HOST TO MSMS IN SEPTEMBER, 1955.**
- **MSMS HOUSE OF DELEGATES** convenes Monday, September 26 at 10:00 a.m., Grand Ball Room, Pantlind Hotel. It will hold three meetings on Monday and two meetings on Tuesday, September 27.
- **THE PROGRAM OF THE ASSEMBLY** for the 90th Annual Session of the Michigan State Medical Society lists guest speakers from all parts of the United States. They are the usual stars in the medical world who always grace the podium at annual conventions of the Michigan State Medical Society; they insure a valuable concentrated continuation course in all phases of medicine and surgery for the busy practitioners of Michigan, neighboring states and the Province of Ontario, on September 28-29-30.
- **REGISTRATION,** Tuesday afternoon through Friday afternoon, September 27-30, Civic Auditorium. Advance registration—on Tuesday and early Wednesday morning—will save the doctors' time. Present your State Medical Society or Canadian Medical Association membership card to expedite registration.

  NO REGISTRATION FEE FOR STATE MEDICAL SOCIETY AND CMA MEMBERS.

  Doctors of Medicine, who are not members of their state medical society or of the Canadian Medical Association, will be accorded the privileges of the MSMS Annual Session upon payment of a $25.00 registration fee.
- **REGISTER AS SOON AS YOU ARRIVE. ADMISSION BY BADGE ONLY.**
- **ALL SUBJECTS** at the MSMS Annual Session are applicable to clinical medicine. They stress diagnosis and treatment, usable in everyday practice.
- **POSTGRADUATE CREDITS** given to every MSMS member who attends MSMS Annual Session.
- **SIX ASSEMBLIES** and one public meeting—fourteen Section Meetings—three Discussion Conferences, all on September 28-29-30.
- **A DISCUSSION CONFERENCE**—featuring the guest speakers of each day—will be held daily from 12:00 noon to 1:00 p.m. in the Black and Silver Room of the Civic Auditorium. Audience participation invited.
- **SECTION MEETINGS** will follow the daily Assemblies—5:00 to 6:00 p.m.
- **PAPERS WILL BEGIN AND END ON TIME.** This scientific meeting will feature by-the-clock promptness and regularity.
- **TECHNICAL AND SCIENTIFIC EXHIBITS** will contain much of interest and value. Intermissions to view the exhibits have been arranged.
- **C. ALLEN PAYNE, M.D., AND FELIX S. ALFENITO, M.D., OF GRAND RAPIDS** are co-chairmen of the Committee on Arrangements for the 1955 MSMS Annual Session.
- **WALTER I. LILLIE, M.D., OF GRAND RAPIDS** is Chairman of the Scientific Exhibit for the 1955 MSMS Annual Session.
- **CABARET-STYLE DANCE AND ENTERTAINMENT,** with the compliments of the Michigan State Medical Society, will be held in the Grand Ball Room of the Pantlind Hotel on Thursday evening, September 29. All who register, and their ladies, will receive a card of admission and are cordially invited to attend.
- **THE WOMAN'S AUXILIARY** to the Michigan State Medical Society will present an attractive social and busines program at the Pantlind Hotel. The wife of every MSMS member is cordially invited to attend.
- **MEMBERS OF MICHIGAN MEDICAL SERVICE** will meet in annual session, Tuesday, September 27, at 2:00 p.m. This meeting will follow the annual MMS luncheon to be held in the Grand Ball Room of the Pantlind Hotel.

SCIENTIFIC ASSEMBLY

Wednesday-Thursday-Friday, September 28-29-30, 1955

SAVE AN ORDER FOR THE EXHIBITOR AT THE MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION

Michigan State Medical Society

The Ninetieth Annual Meeting

PANTLIND HOTEL, GRAND RAPIDS, SEPTEMBER 26-27, 1955

HOUSE OF DELEGATES
ORDER OF BUSINESS*

MONDAY, SEPTEMBER 26

Grand Ball Room, Pantlind Hotel, Grand Rapids

10:00 a.m.—First Meeting

1. **Call to order by Speaker**
2. **Report of Committee on Credentials**
3. **Roll call**
4. **Appointment of Reference Committees**
   - (a) On Officers Reports
   - (b) On Reports of The Council
   - (c) On Reports of Standing Committees
   - (d) On Reports of Special Committees
   - (e) On Constitution and By-Laws
   - (f) On Resolutions
   - (g) On Special Memberships
   - (h) On Rules and Order of Business
   - (i) On Legislation and Public Relations
   - (j) On Hygiene and Public Health
   - (k) On Medical Service and Prepayment Insurance
   - (l) On Miscellaneous Business
   - (m) On Executive Session
   - (n) On Emergency Medical Service
5. **Speaker's Address—J. E. Livesay, M.D., Flint**
6. **President's Address—R. H. Baker, M.D., Pontiac**
7. **President-Elect's Address—W. S. Jones, M.D., Menominee**
8. **Annual and Supplemental Reports of The Council—William Bromme, M.D., Detroit, Chairman**
9. **Report of Delegates to American Medical Association—W. A. Hyland, M.D., Grand Rapids, Chairman**
10. **Brief of Annual Report of Woman's Auxiliary —Mrs. A. F. Milford, Ypsilanti, President**
11. **Brief of Annual Report of Michigan State Medical Assistants Society—Mrs. Charlotte Ash, Kalamazoo, President**
12. **Selection of Michigan's Foremost Family Physician**

1:00 p.m. LUNCHEON, Continental Room

PANEL ON UNDERGRADUATE MEDICAL EDUCATION

Moderator

J. E. Livesay, M.D., Flint, Speaker, MSMS House of Delegates

Participants

A. C. Furstenberg, M.D., Ann Arbor, Dean, University of Michigan Medical School

G. H. Scott, Ph.D., Detroit, Dean, Wayne University College of Medicine

MONDAY, SEPTEMBER 26

Grand Ball Room, Pantlind Hotel, Grand Rapids

2:00 p.m.—Second Meeting

13. **Supplementary Report of Committee on Credentials**
14. **Roll call**
15. **Resolutions****
16. **Reports of MSMS Standing Committees:**
    - A. Committee on Postgraduate Medical Education
    - B. Preventive Medicine Committee:
      - (1) Committee on Rheumatic Fever Control
      - (2) Cancer Control Committee
      - (3) Maternal Health Committee (and Subcommittees)
      - (4) Venereal Disease Control Committee
      - (5) Tuberculosis Control Committee
      - (6) Industrial Health Committee
      - (7) Mental Health Committee
      - (8) Child Welfare Committee (and Subcommittees)
      - (9) Iodized Salt Committee
      - (10) Geriatrics Committee (and Subcommittees)
    - C. Public Relations Committee (and Subcommittees)
    - D. Ethics Committee
    - E. Legislative Committee
17. **Reports of Special Committees**
    - A. Beaumont Memorial Committee
    - B. Scientific Radio Committee
    - C. Advisory Committee to Woman's Auxiliary
    - D. Advisory Committee to Michigan State Medical Assistants Society

Reports of the Committees of The Council, including Committee on Scientific Work, are included in Annual Report of The Council.

MONDAY, SEPTEMBER 26

Grand Ball Room, Pantlind Hotel, Grand Rapids

8:00 p.m.—Third Meeting

18. **Supplementary Report of Committee on Credentials**
19. **Roll call**
20. **Unfinished business**
21. **New business**
22. **Reports of Reference Committees:**
    - (a) On Officers' Reports
    - (b) On Reports of The Council
    - (c) On Reports of Standing Committees
    - (d) On Reports of Special Committees
    - (e) On Constitution and By-Laws
    - (f) On Resolutions
    - (g) On Special Memberships
    - (h) On Rules and Order of Business
    - (i) On Legislation and Public Relations
    - (j) On Hygiene and Public Health
    - (k) On Medical Service and Prepayment Insurance
    - (l) On Miscellaneous Business
    - (m) On Executive Session
    - (n) On Emergency Medical Service

*See the Constitution, Articles IV, VII and XII, and the By-Laws, Chapter 8 on "House of Delegates."

**All resolutions, special reports, and new business shall be presented in writing in triplicate (By-Laws, Chapter 8, Section 10-m).

TUESDAY, SEPTEMBER 27

Grand Ball Room, Pantlind Hotel, Grand Rapids

9:30 a.m.—Fourth Meeting

23. **Supplementary Report of Committee on Credentials**
24. **Roll call**
25. **Unfinished business**
26. **New business**
27. **Supplementary Reports of Reference Committees**

TUESDAY, SEPTEMBER 27

Grand Ball Room, Pantlind Hotel, Grand Rapids

8:00 p.m.—Fifth Meeting

28. **Supplementary Report of Committee on Credentials**
29. **Roll call**
30. **Unfinished business**
31. **Supplemental Report of The Council**
32. **Supplementary Reports of Reference Committees**
33. **Elections:**
    (a) Councilors:
    2nd District—R. S. Breakey, M.D., Lansing—Incumbent
    3rd District—G. W. Slagle, M.D., Battle Creek—Incumbent
    15th District—D. Bruce Wiley, M.D., Utica—Incumbent
    16th District—G. T. McKean, M.D., Detroit—Incumbent
    (b) Delegates to American Medical Association:
    W. D. Barrett, M.D., Detroit—Incumbent
    W. A. Hyland, M.D., Grand Rapids—Incumbent
    R. A. Johnson, M.D., Detroit—Incumbent
    (c) Alternate Delegates to American Medical Association:
    W. W. Babcock, M.D., Detroit—Incumbent
    O. J. Johnson, M.D., Bay City—Incumbent
    E. F. Sladek, M.D., Traverse City—Incumbent
    (d) President-elect
    (e) Speaker of the House of Delegates
    (f) Vice-Speaker of the House of Delegates
34. **Adjournment.**

ADVANCE REGISTRATION OF DELEGATES

Sunday, September 25, 1955

8:00 to 10:00 p.m.

Lobby of Pantlind Hotel

REGISTRATION

also on

Monday, September 26, 1955

8:00 a.m.

Lobby of Pantlind Hotel

ANNUAL SESSION APPOINTMENTS

- *Co-chairmen of Arrangements*

  C. Allen Payne, M.D., and
  Felix S. Alfenito, M.D., Grand Rapids

- *Chairman of Scientific Exhibit*

  Walter I. Lillie, M.D., Grand Rapids

- *House of Delegates Press Relations Committee*

  K. H. Johnson, M.D., Chairman
  L. C. Carpenter, M.D.
  L. Fernald Foster, M.D.
  R. A. Johnson, M.D.
  J. E. Livesay, M.D.
  C. L. Weston, M.D.

- *Scientific Assembly Press Relations Committee*

  P. W. Kniskern, M.D., Chairman
  H. G. Benjamin, M.D.
  F. C. Brace, M.D.
  C. A. Payne, M.D.
  L. Paul Ralph, M.D.

HOTEL RESERVATIONS
MICHIGAN STATE MEDICAL SOCIETY
90th Annual Session
Grand Rapids, September 28-29-30, 1955

The reservation blank below is for your convenience in making your hotel reservations in Grand Rapids. Please send your application to the Committee on Hotels for MSMS Convention, Pantlind Hotel, Grand Rapids, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Committee on Hotels by sharing a room with another registrant, when convenient.

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Committee on Hotels,
Michigan State Medical Society
c/o Pantlind Hotel
Grand Rapids, Michigan

Please make hotel reservation(s) as indicated below:

..... Single Room(s) ..... persons

..... Double Room(s) for ..... persons

..... Twin-Bedded Room(s) for ..... persons

Arriving September ..... hour ..... A.M. ..... P.M.

Leaving ..... hour ..... A.M. ..... P.M.

Hotel of First Choice: .....

Second Choice: .....

Names and addresses of all applicants including person making reservation:

Name	Address	City	State
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Date ..... Signature .....

Address ..... City .....

MSMS HOUSE OF DELEGATES, 1955

Delegates and Alternates

(Names of Alternates appear in Italics)

OFFICERS

J. E. Livesay, M.D., 621 Mott Foundation Bldg., Flint, Speaker
K. H. Johnson, M.D., 1116 Michigan National Tower, Lansing, Vice-Speaker
L. Fernald Foster, M.D., 919 Washington, Bay City, Secretary
L. W. Hull, M.D., 1701 David Whitney Bldg., Detroit, Immediate Past President

ALLEGAN

L. F. Brown, M.D., Otsego
E. B. Johnson, M.D., Allegan

ALPENA-ALCONA-PRESQUE ISLE

E. S. Parmenter, M.D., P.O. Box 192, Alpena
J. E. Spens, M.D., Professional Bldg., Alpena

BARRY

A. B. Gwinn, M.D., City Bank Bldg., Hastings
H. S. Wedel, M.D., 134 E. State St., Hastings

BAY-ARENAC-IOSCO

O. J. Johnson, M.D., 207 N. Walnut, Bay City
D. A. Bowman, M.D., 101 W. John St., Bay City
W. G. Gamble, M.D., Mercy Hospital, Bay City
M. J. Medvesky, M.D., 1106 S. Madison Ave., Bay City

BERRIEN

D. W. Thorup, M.D., 610 Fidelity Bldg., Benton Harbor
N. J. Hershey, M.D., 1648 Broadway, Niles
F. A. Rice, M.D., Niles
H. J. Klos, M.D., Mercy Hosp., Benton Harbor

BRANCH

H. J. Meier, M.D., 87 W. Pearl St., Coldwater
R. J. Fraser, M.D., 22 W. Pearl St., Coldwater

CALHOUN

H. C. Hansen, M.D., 417 Post Bldg., Battle Creek
L. R. Keagle, M.D., 196 North Ave., Battle Creek
J. W. Hubly, M.D., 1407 Security Tower, Battle Creek
S. B. Winslow, M.D., 612 Post Bldg., Battle Creek

CASS

S. L. Loupee, M.D., Dowagiac
U. M. Adams, M.D., Marcellus

CHIPPEWA-MACKINAC

W. F. Mertaugh, M.D., Central Savings Bank Bldg., Sault Ste. Marie
E. S. Rhind, M.D., 300 Court St., Sault Ste. Marie

CLINTON

F. W. Smith, M.D., St. Johns
A. C. Henthorn, M.D., Route 3, St. Johns

DELTA-SCHOOLCRAFT

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THE NINETIETH ANNUAL MEETING

HOUSE OF DELEGATES, 1955

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J. Earl McIntyre, M.D.

A man who was to become known as "Dr. State Board of Medicine" to thousands of medical students and M.D.'s in Michigan first met a member of the medical profession in Bettsville, Ohio, on February 15, 1884. At that initial encounter there was little of the dignity and understanding that was later to mark his contact with medical men; only a sharp slap on the backside by the doctor and a loud wail from the infant who was to be named J. Earl McIntyre, a signature which you will find on an important piece of parchment hanging somewhere in the offices of most M.D.'s of Michigan.

The "M.D." was added after J. Earl McIntyre's name in 1908 when he was graduated from the former Detroit College of Medicine, now Wayne University College of Medicine. Internship and a year's residency in internal medicine at Harper Hospital followed his graduation; then he returned to Lansing which had become his home town. He has remained in Michigan's Capital City ever since, engaging in active practice for 40 years with the exception of time spent along the Mexican border chasing Pancho Villa during 1916 and 1917 as a Captain in the 11th Provisional Field Artillery.

He had already given up his bachelorhood in 1914 to marry Sally Barclay of Menominee.

From that union, the name of McIntyre will continue in the medical circles of Michigan, for Jack B. McIntyre, M.D., Dr. and Mrs. McIntyre's one son, now is in residency training at Henry Ford Hospital, Detroit. And already the possibility of a third generation Dr. McIntyre has appeared, since one of J. Earl's two grandchildren is a boy.

To anyone so diligent and hardworking as the young J. Earl McIntyre, it was only natural that he was to have many interests outside his devotion to his first love, the private practice of medicine. From his earliest days in Lansing, Dr. McIntyre took an active part in medical and professional organizations on both the local and state level. One of his early extra-curricular jobs was as member and secretary of the original Board of Control of the Ingham County Tuberculosis Sanatorium in 1912. Dr. Mac also was county physician in 1912 and later was coroner of Ingham County during 1920-22. For 25 years from 1920 to 1945, he was member and President of the Lansing Board of Health.

His interest in medical organization grew and he became President of the Ingham County Medical Society in 1925, and later a member of The MSMS Council and its Executive Committee.

All this activity was bound to attract attention. In 1928 he was appointed to the State Board of Registration in Medicine, later becoming its President, and, for the past 22 years, its Secretary.

In 1933, when the offices of the State Boards were moved to Lansing from Detroit, Dr. Mac was Board President. Therefore he was surprised when the Governor handed him the key to the new office. When he protested that he was not the Secretary, the Governor advised him that as of that moment J. Earl McIntyre, M.D., was both President and Secretary. Shortly thereafter, when the Board unanimously elected Dr. Mac as Secretary, he resigned as President and he put on the badge of office which he has worn ever since.

With that badge firmly affixed, Dr. McIntyre

took up his guard post at the portals of Michigan medicine, jealously protecting them against cultists and other pseudo doctors and from the product of sub-standard and inferior medical schools. The result: Michigan has maintained one of the highest standards of medical education and licensure in the entire United States.

In this position, he has served as father advisor and counselor to a multitude of medical students and young doctors. Many—some now leaders in their particular fields of medicine—were persuaded personally by Dr. Mac to stick out their medical education after facing the discouragement which at one time or another comes to almost every medical student when he finds there's no easy path leading to an M.D. degree.

Such a busy schedule as Dr. Mac cut out for himself finally led in 1950 to an attack of what has been called in some quarters the occupational disease of the M.D.—a coronary occlusion. With that, he gave up even part-time private medical practice, and today his pet gripe is "they won't let me do anything to even smell like a man"—the result of a strict diet, with no hard beverages or tobacco. There are a few diehard ex-patients, however, like the man who walked into the office of the State Board recently and insisted that he wanted a complete physical examination right then and there, much to the consternation of the staff.

Through his years as Secretary of the State Board of Medicine, Dr. Mac has time and again stopped action from many sources to lower the standards of medical licensure in Michigan; he has resisted or ignored pressures of many kinds from many places where there was a question that the credentials of an applicant were not adequate by Michigan standards.

Anecdotes of events serious at the time, but mellowed through the years, are many. Perhaps the favorite concerns the time he discovered that two young men, newly arrived for internship at one of Michigan's approved training hospitals, were actually graduates in a healing art which still officially bears the label of "cult." The two young gentlemen were promptly and quietly escorted to the state line, under Dr. McIntyre's direction, carefully stripped of their phony credentials.

Full realization of how much of his life has been devoted to the State Board of Medicine came suddenly the other day when Dr. McIntyre signed the license of a young M.D. and then remembered that in his own first year as a member of the State Board he had delivered the newly licensed doctor and signed his birth certificate.

Coronary or no coronary, however, you can't keep a man like J. Earl McIntyre from seeking new worlds to conquer, even though practice of medicine is a thing of the past. His great crusade today is the development of a Uniform Medical Practice Act, acceptable for the entire United States. This has been a project thrust upon him as a Committee member for the Federation of State Medical Boards of the United States, of which he was President in 1941-42, the first M.D. from Michigan to be so honored. Another honor of which he has reason to be proud is his membership on the National Board of Medical Examiners from 1945 to 1954.

Right now the possibility of an influx of men holding M.D. degrees from colleges and universities beyond the borders of the United States and Canada is of considerable concern to members of the State Board of Registration and its Secretary. Methods for assuring that only those who can qualify under the standards set in Michigan for American-trained doctors of medicine are their present goal. And it's a good bet that J. Earl McIntyre, in his position as guardian of the portals, will find a way.

—A. C. FURSTENBERG, M.D.

TRICHOPHYTON TONSURANS RINGWORM

(Continued from Page 690)

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Mrs. Charlotte Ash

Medical Assistant, Magna Cum Laude

At the 90th Annual Session in Grand Rapids, if you should run into a very attractive woman, smartly clothed and wearing an equally smart hat, she is very likely to be Mrs. Charlotte Ash, President of the Michigan State Medical Assistants Society for 1955.

Charlotte was born in Vicksburg, Michigan, and was graduated from Vicksburg High School and Parsons Business College. Her ambition while attending high school was not to work in a business office but to become a Registered Nurse. Also, she thought a great deal about entering law school, but an illness, and the depression with its lean years, made the furthering of that ambition an impossibility. Business college was the alternative.

She says that she felt fortunate to obtain work in the "Dirty Thirties" since jobs were few and far between. Upon completion of business college, Charlotte worked for a time for a manufacturer of fretted string instruments in the credit department; and at that time, being a busy doctor's right hand was farthest from her mind.

She married and after her son, now fifteen years old and a sophomore in high school, was born, she remained at home for about three years, although during this period she was active in community affairs assisting with the work of the Rationing Board in Kalamazoo.

Eight years ago, she began working in the office of Homer Stryker, M.D., of Kalamazoo, as a medical assistant. When she started this work, Dr. Stryker was in private practice alone. However, a year later R. Grant Howard, M.D., joined him, and four years later Robert E. DeLong, M.D., became associated.

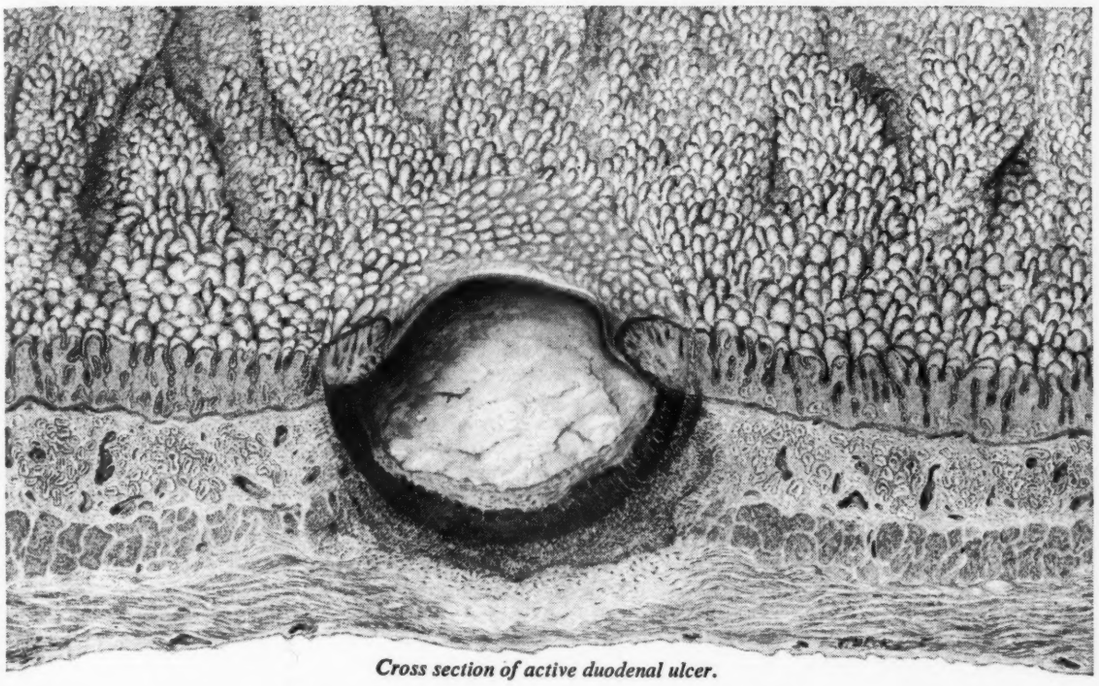
Since that time, Charlotte has continued to be "our girl Friday" to these three hard-working physicians. She has carried the tremendous load without apparent effort. Her co-workers have stated that she is never critical and never expects others to carry her burden of work for her, but always finds time to lend a helping hand to those who need it. She is always even-tempered and pleasant to everyone. It is no small job to keep an office for three busy specialists running smoothly and efficiently, and this she does with one asistant.

Mrs. Ash is a charter member of the Kalamazoo County Medical Assistants Society and became its President in 1951. The previous year, 1950, she served on the Membership Committee of the MSMAS and in 1953 served as Chairman of the Convention Committee in Grand Rapids. This was a major undertaking and Charlotte spent many long hours planning for that function. At this Convention, Mrs. Ash was voted into office as President-Elect of MSMAS and took office as President in September, 1954.

Charlotte has always been active in her church and its organizations. She is a member of the Eastern Star in Vicksburg, and the Library and Child Study clubs. Too, she found politics interesting and has been active in her party organization. She says she enjoys being "the crew" for her husband's fleet of Snipe boats which are kept on a lake near their home.

Along with her home, her family, her work as a Medical Assistant, and the various activities in connection with being President of the Michi-

(Continued on Page 748)



Cross section of active duodenal ulcer.

Dramatic Remission of Ulcer Pain

Pain of ulcer is associated with hypermotility; the pain is relieved when abnormal motility is controlled by Pro-Banthīne.

"In studying[1] the mechanism of ulcer pain, it is obvious that there are at least two factors which must be considered: namely, hydrochloric acid and motility.

". . . our studies indicate that ulcer pain in the uncomplicated case is invariably associated with abnormal motility. . . .

"Prompt relief of ulcer pain by ganglionic blocking agents . . . coincided exactly with cessation of abnormal motility and relaxation of the stomach."

Pro-Banthine Bromide (β-diisopropylaminoethyl xanthene-9-carboxylate methobromide, brand of propantheline bromide) is a new, improved, well tolerated anticholinergic agent which consistently reduces hypermotility of the stomach and intestinal tract. In peptic ulcer therapy[2] Pro-Banthine has brought about dramatic remissions, based on roentgenologic evidence. Concurrently there is a reduction of pain, or in many instances, the pain and discomfort disappear early in the program of therapy.

One of the typical cases cited by the authors[2] is that of a male patient who refused surgery despite the presence of a huge crater in the duodenal bulb.

"This ulcer crater was unusually large, yet on 30 mg. doses of Pro-Banthine [q.i.d.] his symptoms were relieved in 48 hours and a most dramatic diminution in the size of the crater was evident within 12 days."

Pro-Banthine is proving equally effective in the relief of hypermotility of the large and small bowel, certain forms of pylorospasm, pancreatitis and ureteral and bladder spasm. G. D. Searle & Co., Research in the Service of Medicine.

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SEARLE

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

HEARING AID PROJECT

Hearing aids for children whose parents are unable to buy them are purchased by the Michigan Department of Health. Instruments are purchased for children with permanent hearing losses who cannot hear speech adequately but who, with a hearing aid, would be able to attend classes with normal hearing children. Needy children under sixteen years of age, where otological examination has established the fact that the child has a hearing defect which is permanent, are eligible for help providing that the child's parents are interested and co-operative and the child can use a hearing aid adequately.

Instruments are selected by standard audiological methods at non-commercial centers, such as the University of Michigan, Ann Arbor; Michigan State College, East Lansing; Michigan School for the Deaf, Flint; Detroit Hearing Center, and the Constance Brown Society for Better Hearing in Kalamazoo.

The children may be trained in the use and care of the hearing aid by teachers of the deaf and hard of hearing in their own communities. For children living where local facilities are not available, short training programs have been established at the Michigan School for the Deaf in Flint and the Bay Cliff Health Camp in the Upper Peninsula. Here children with new hearing aids learn how to use and care for the instruments properly and are given short intensive work in auditory training, language development and understanding, lip reading and speech correction.

Over 200 children have been helped in the project and are competing successfully with normal hearing children in our public schools.

FIRST COMMUNITY MULTIPLE SCREENING PROJECT POPULAR

Michigan's first multiple screening study on a community-wide basis opened April 25 in Livingston County, to continue through May 20. During the first week, in one of the three centers in the county, 1,001 persons were screened, taxing both laboratory facilities and examining staff. The project is under the sponsorship of the Livingston County Medical Society, the Livingston County Chapter of the Michigan Division of the American Cancer Society and the Michigan Department of Health.

PROPHYLACTICS OTHER THAN SILVER NITRATE

Physicians frequently raise questions regarding the Michigan laws and regulations governing the use of prophylactic agents in the prevention of ophthalmia neonatorum.

According to Act 328, Public Acts of 1931—"It shall be the duty of the state health commissioner to officially name and approve a prophylaxis to be used in treating the eyes of newly born infants, and it shall be the duty of the commissioner to publish instructions for using the same."

The Commissioner of Health has compiled with the law by naming 1% silver nitrate, in solution, as the prophylactic which must be used by any physician, nurse or midwife who assists or is in charge at the birth of any infant.

However, as there seemed to be so much interest in the use of prophylactics other than silver nitrate, in October, 1953, the Commissioner of Health and the Council of Health approved a modification to the regulation requiring the use of silver nitrate, stating that other prophylactics under controlled research conditions might be used if requests for such research studies had been previously approved by the state health commissioner.

SUMMER TOPICAL FLUORIDE PROGRAM CONTINUES

The increasingly popular summer program of topical application of fluoride to children's teeth is well started on its fifth year. Schedules are being set up in 170 different locations in forty-two Michigan counties and some 30,000 boys and girls from three to thirteen years of age are expected to receive the fluoride treatments.

The treatments will be given by fifty-five dental students from the University of Michigan and the University of Detroit—junior dentists and dental hygienists. After an intensive training period, they will work in close co-operation with local dentists, health departments and school and civic groups in the localities included in the program. A nominal fee charged each child who can pay reimburses the students for living expenses. This makes the program practically self-supporting.

Treatment consists of a series of four applications of fluoride which prevent about 40 per cent of new dental decay.

Programs of topical application of fluoride are especially indicated for areas not served by a municipal water supply. They are also advised for about six years after water fluoridation has been initiated in a community, to provide protection for children whose teeth have wholly or partially developed on non-fluoridated water.

The place for examination of persons with cancer symptoms is the private physician's office or a cancer diagnostic clinic rather than a detection center.

* * *

More perspiration and less publicity should be expended on cancer research.

Now! G-E offers you a 200-ma x-ray unit

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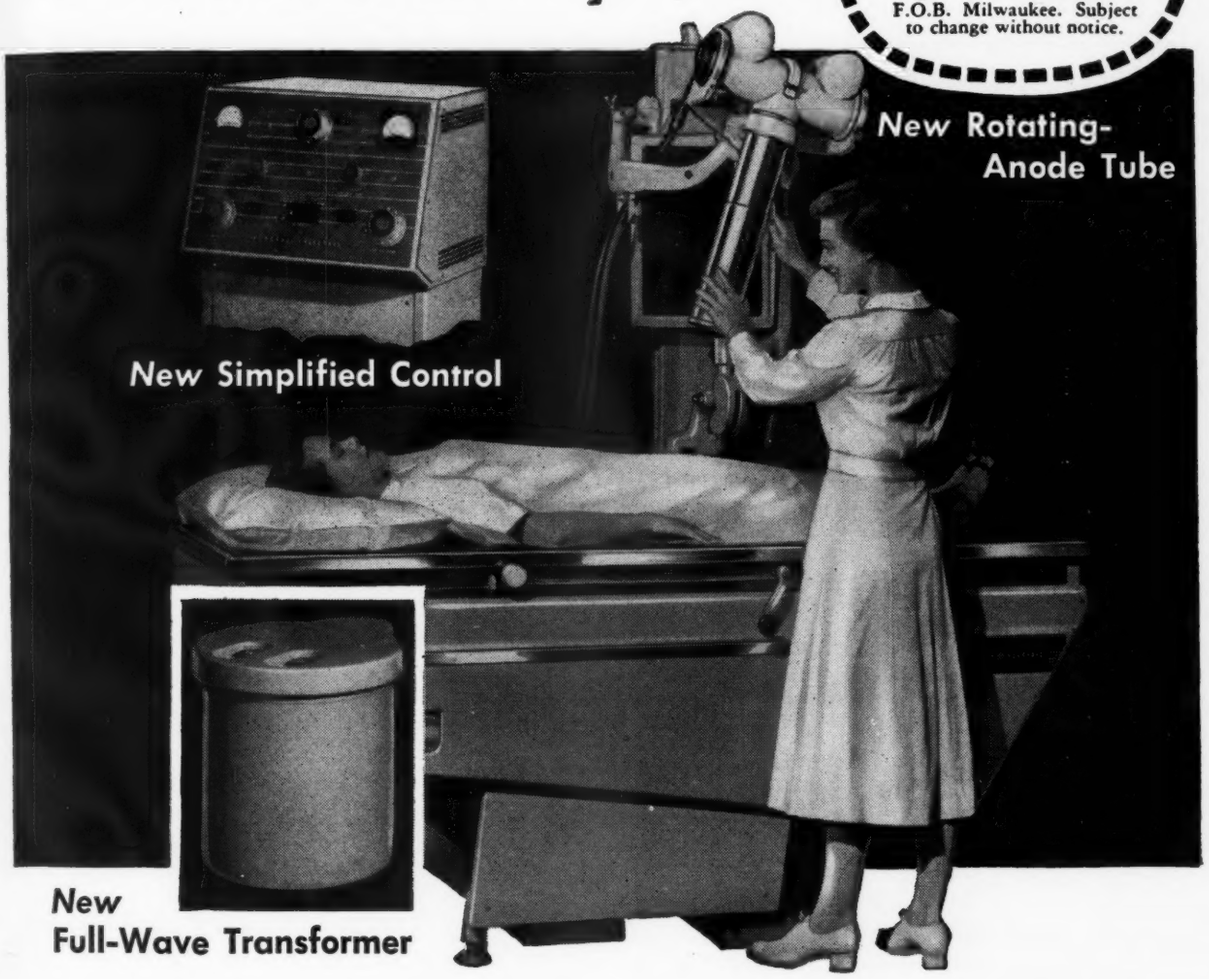

YOU don't have to be handicapped by under-powered, inflexible x-ray apparatus. General Electric not only gives you the Maxicon ASC — *a full-length table of rigid construction* — but also offers you all this for complete fluoroscopic and radiographic facilities: a new simplified 200-ma control unit . . . a new lightweight rotating-anode tube . . . a new full-wave x-ray transformer

That $4900 price includes, in addition, electronic timing, 1/20 to 10 seconds . . . 8:1 Bucky diaphragm . . . and fluoroscopic screen. At extra cost — motor-drive table angulation, spot-film device and 16:1 Bucky diaphragm.

Now's the time to step up your radiographic facilities. And, remember, you can get the Maxicon ASC — without initial capital investment—on the G-E Maxiservice® rental plan. For full information, see your G-E x-ray representative. Or, if you prefer, write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin.

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MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION

Civic Auditorium—Pantlind Hotel, Grand Rapids
Wednesday-Thursday-Friday, September 28, 29, 30, 1955
YOU are invited to attend the Ninetieth

MICHIGAN AUTHORS

Isodore Lampe, M.D., Ann Arbor, is the author of an article entitled "Results from Radiation Treatment in Cancer of the Buccal Mucosa and Lower Gingiva," published in *American Journal of Rentgenology, Radium Therapy, and Nuclear Medicine,* April, 1955.

Thomas Francis, Jr., M.D., Ann Arbor, is the author of an article entitled "Approach to Control of Poliomyelitis by Immunological Methods," published in the *Bulletin of the New York Academy of Medicine,* April, 1955.

H. E. Carnes, M.D., J. E. Gajewski, M.D., J. H. Conlin, M.D., Detroit, and **P. N. Brown, M.D.,** Northville, are the authors of an article entitled "Experimental Treatment of Typhoid Carriers," published in *Henry Ford Hospital Medical Bulletin,* March, 1955.

Gordon A. Eadie, M.D., Detroit, is the author of an article entitled "Lessons Learned from the Detroit Transmission Division Fire of August 12, 1953," published in *Henry Ford Hospital Bulletin,* March, 1955.

James Clark Moloney, M.D., Detroit, is the author of an article entitled "Etiology of Mental Health," published in *Henry Ford Hospital Bulletin,* March, 1955.

Harry M. Nelson, M.D., Detroit, is the author of an article entitled "Cancer Detection," published in the *Henry Ford Hospital Bulletin,* March, 1955.

E. Osborne Coates, Jr., M.D., Detroit, is the author of an article entitled "Some Practical Applications of Pulmonary Function Studies in Chest Disease," published in *Henry Ford Hospital Bulletin,* March, 1955.

Robert L. Weiner, M.D., Eloise, and **Harold F. Falls, M.D.,** Ann Arbor, are the authors of an article entitled "Intermediate Sex-Linked Retinitis Pigmentosa" published in AMA *Archives of Ophthalmology,* April, 1955.

R. K. Ratliff, M.D., F.A.C.S., and **W. B. Crenshaw, M.D.,** Ann Arbor, are the authors of an article entitled "Ureteral Obstruction From Endometriosis" published in *Surgery, Gynecology and Obstetrics,* April, 1955.

Robert T. Crowley, M.D., F.A.C.S., New York, N. Y., and **Warren O. Nickel, M.D.,** Detroit, are the authors of an article entitled "Definitive Treatment of Decubitus Ulcers in Paraplegic Patients by Coverage with Transposition Bilobed Flap Grafts," published in *Surgery, Gynecology and Obstetrics,* April, 1955.

Harry M. Nelson, M.D., Detroit, is the author of an article entitled "Progress in Cancer Control," published in *American Practitioner and Digest of Treatment,* February, 1955.

G. C. Brown, M.D., A. S. Babson, M.D., J. H. Schieble, M.D., Ann Arbor, are the authors of an article entitled "The Effect of Gamma Globulin on Subclinical Infection in Familial Associates of Poliomyelitis Cases. II. Serological Studies and Virus Isolations from Pharyngeal Secretions" published in the *Journal of Immunology,* January, 1955.

D. L. Waters, M.D., D. G. Dickinson, M.D., and **J. L. Wilson, M.D.,** Ann Arbor, are the authors of an article entitled "Clinical Evaluation of Pulmonary and Thoracic Elasticity In Chronic Poliomyelitis Patients," published in AMA *American Journal of Diseases of Children,* January, 1955.

William S. Reveno, M.D., Detroit, is the author of an article entitled "Periodic Health Appraisals—a Boon for Patients," published in the *Journal of the Student American Medical Association,* May, 1955.

Norman F. Miller, M.D., Ann Arbor, is the author of an article entitled "Terminal Care for the Gynecologic Cancer Patient," published in the *Journal of the Indiana State Medical Association,* April, 1955.

H. D. Ireland, M.D., F.A.C.P., Grand Rapids, is the author of an article entitled "Emotional Problems of Tuberculosis Hospital Patients" published in THE JOURNAL of the Michigan State Medical Society, a condensation of which is published in the *American Practitioner and Digest of Treatment,* April, 1955.

George H. Koepke, M.D., Alma J. Murphy, Ph.D., James W. Rae, Jr., M.D., and **David G. Dickinson, M.D.,** Ann Arbor, are the authors of an article entitled "An Electromyographic Study of Some of the Muscles Used in Respiration," read at the Thirty-second Annual Session of the American Congress of Physical Medicine and Rehabilitation, Washington, D. C., September 8, 1954, and published in *Archives of Physical Medicine and Rehabilitation,* April, 1955.

Donald R. Hagge, M.D., Detroit, is the author of an article entitled "Anatomy of the Recurrent Laryngeal Nerves in Thirty-Five Dissected Specimens," published in *Harper Hospital Bulletin,* January-February, 1955.

Harold Henderson, M.D., Detroit, is the author of an article entitled "Uterine Cancer—Salient Points from the 1954 International Congress of Obstetrics and

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Gynecology, Geneva," published in *Harper Hospital Bulletin,* January-February, 1955.

Aran S. Johnson, M.D., Detroit, is the author of an article entitled "Small Bowel Obstruction By a Vegetable Bezoar—Case Report," published in *Harper Hospital Bulletin,* January-February, 1955.

John M. Hammer, M.D., Albert DeGroat, M.D., and John R. MacGregor, M.D., Kalamazoo, are the authors of an article entitled "Atabrin in the Treatment of Trichomonas Infestation of the Prostate," published in *Clinical Medicine,* April, 1955.

Milton J. Steinhardt, M.D., F.A.C.A., Detroit, is the author of an article entitled "Urticaria and Angioedema, Statistical Survey of Five Hundred Cases" published in *Annals of Allergy,* November-December, 1954.

E. S. Gurdjian, M.D., J. E. Webster, M.D., F. R. Latimer, M.D., S. P. Klein, M.D., and J. E. Lofstrom, M.D., Detroit, are authors of an original article "Recent Advances in Surgical Management of Chromophobe Tumor of Pituitary" which appeared in *JAMA* of May 7, 1955.

B. I. Hirschowitz, M.D., D. H. P. Streeten, Dh.Phil., H. M. Pollard, M.D., and H. A. Boldt, Jr., M.D., Ann Arbor, are authors of an original article "Role of Gastric Secretions in Activation of Peptic Ulcers by Corticotropin (ACTH)" which appeared in *JAMA* of May 7, 1955.

B. E. Brush, M.D., and T. J. Heldt, M.D., Detroit, are authors of an article under Clinical Notes, *The Journal of the American Medical Association,* May 7, 1955 number, entitled "A Device for Relief of Lymphedema."

Coleman Mopper, M.D., Herman Pinkus, M.D., and Peter Jacobell, M.D., Detroit, are authors of an original article "Multiple Sweat Gland Absesses of Infants" which appeared in *Archives of Dermatology,* February, 1955.

Kenneth A. Wood, M.D., and Laurence A. Pratt, M.D., Detroit, are authors of an original article "Alveolar Cell Tumor of Lung" which was published in the Grace Hospital *Bulletin,* Detroit.

* * *

Report on Problem of Fee Splitting.—*JAMA,* May 7 issue (pages 49-50 of the Organization Section) publishes the report of the Committee on Medical Practices, appointed in 1954, to study the problem of fee splitting. The report, presented to the AMA House of Delegates in Atlantic City on June 6, recommends that:

1. A Subcommittee be created to work on a relative value scale such as that produced by the thoracic surgeons. This scale, based on points and not dollars, would apply to the whole of the practice of medicine and surgery. It would indicate the proper relation between fees for various medical and surgical specialties.
2. A program of public education by the AMA Department of Public Relations on the value of diagnostic and medical work be fostered to increase the public's appreciation of non-surgical work.

(Continued on Page 736)

Particularly now...

Why is **KENT** the one fundamentally different filter cigarette?

The more brands of filter cigarettes that are introduced—the more innovations in filtering—the clearer becomes the difference in KENT. Consider for a moment why.

Only KENT, of all filter brands, goes to the extra expense to bring smokers the famous Micronite Filter. All others rely solely on cotton, paper or some form of cellulose.

Indeed, the material in KENT's Micronite Filter is the choice in *many* places where filter requirements are most exacting.

With such filtering efficiency, it is understandable why KENT with the Micronite Filter takes out even microscopic particles —why KENT is *proved* effective in impartial scientific test after test.

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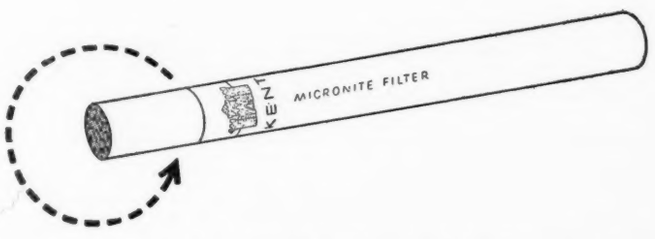

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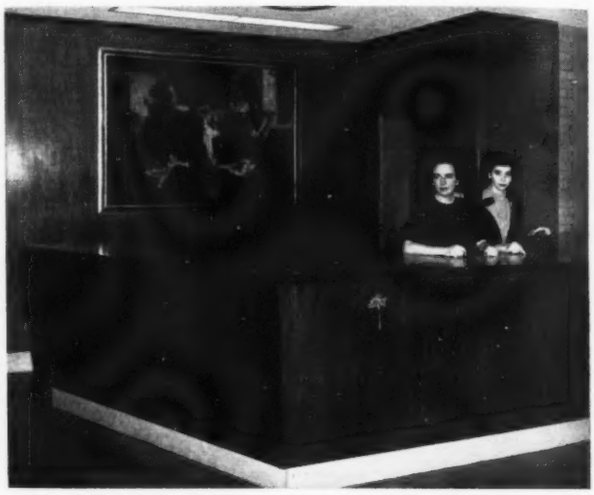
(Continued from Page 734)

3. The American Medical Association encourage the various specialty boards in medicine to reappraise the value of their regulations restricting the practice of those seeking or holding board certificates.

4. The American Medical Association continue to discourage arbitrary restrictions by hospitals against general practitioners.

* * *



Beaumont Hospital Displays Cornwell Painting.—The William Beaumont Hospital of Royal Oak displayed in its waiting room, over a two months' period, the famous Dean Cornwell painting "William Beaumont and Alexis St. Martin," property of the Michigan State Medical Society, through the courtesy of Wyeth, Inc., of Philadelphia who commissioned Dean Cornwell to make this famous painting some fifteen years ago.

The portrait, depicting the historical and revolutionary experiments of Beaumont in stomach physiology, has now been moved to the Beaumont Memorial on Mackinac Island, for public view during the summer months.

* * *

Arizona physicians (488 out of 722) expressed their sentiments on social security in a recent survey conducted by the Arizona Medical Association. While only sixteen physicians favored compulsory social security for doctors, a total of 252 favored a voluntary system of social security for M.D.'s (171 were against a voluntary plan). A voluntary pension plan for the self-employed was favored by 416 (fifty voted in the negative). Only sixty-eight voted in favor of the waiver of premium provisions (for total and permanent disability) while 364 were against.

* * *

Michigan Industrial Medical Association.—The following are officers this year of the MIMA:

President: Paul J. Ochsner, M.D.
President-Elect: Earl E. Weston, M.D.
Vice President: Millard W. Shellman, M.D.
Secretary-Treasurer: S. D. Steiner, M.D.

Oldsmobile Div.
General Motors Corporation
Lansing, Michigan

(Continued on Page 738)

(Continued from Page 736)

The American Public Health Association will hold its 83rd Annual Meeting in Kansas City, Missouri (Municipal Auditorium), November 14-18, 1955. For program and information, write Herman E. Hilleboe, M.D., Health Commissioner, State of New York, in care of 1790 Broadway, New York 19.

* * *

Harry Nelson, M. D., Detroit, spoke to the Saginaw County Medical Society on March 15. His subject was "Cancer Detection."

* * *

Edward F. Domino, M.D., of Ann Arbor, was presented with a research award of $250 by the Michigan Society of Neurology and Psychiatry for "Original research in fields related to Neurology and Psychiatry." Dr. Domino's award was based on his manuscript "Differential Drug Effects on the Brain Stem Activating and Diffuse Thalamic Projection Systems."

A graduate of the University of Illinois Medical School, 1951, Dr. Domino is now assistant professor in pharmacology at the University of Michigan Medical School.

* * *

Michigan Heart Association Officers.—L. Paul Ralph, M.D., Grand Rapids, is President; Earl A. Irvin, M.D., Detroit, is President Elect; L. Fernald Foster, M.D., Bay City, Secretary; and Mr. Charles T. Fisher, Jr., Detroit, Treasurer.

Medical men re-elected to the Board were: Carleton Dean, M.D., Lansing, J. D. Littig, M.D., Kalamazoo, Muir Clapper, M.D., Detroit, Henry L. Smith, M.D., Detroit, Franklin T. Johnston, M.D., Ann Arbor, H. H. Riecker, M.D., Ann Arbor, Frank Van Schoick, M.D., Jackson, Milton Shaw, M.D., Lansing, F. Janney Smith, M.D., Birmingham.

The new headquarters of the Michigan Heart Association are located in the Doctors Building, 3919 John R Street, Detroit (opposite Harper Hospital).

* * *

Michigan United Fund.—The United Health and Welfare Fund of Michigan, Inc., has changed its name —for purposes of brevity—to "Michigan United Fund."

* * *

Doctor Locations.—The Michigan Health Council placed, through April 30, 1955, two additional doctors of medicine: William J. Cameron, M.D., from Denver to Petoskey, Michigan; Walter C. Peltason, M.D., from California to Paw Paw, Michigan.

* * *

The St. Clair County Medical Society's Eleventh Annual Clinic Day, held in Port Huron, May 20, presented the following guest speakers: Oscar D. Ratnoff, M.D., Cleveland, George J. Gabuzda, M.D., Cleveland, Phillip

(Continued on Page 740)

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D. Partington, M.D., Cleveland, Lawrence William Gardner, M.D., Detroit, and James C. Wolter, M.D., Detroit. The meeting was presided over by L. F. McCoy, M.D., under the presidency of James Lauridsen, M.D.

* * *

Your Choice of AMA Journals: Dues-paying members of the American Medical Association receive their choice of either *The Journal of the AMA* or one of the nine special journals as a benefit of paid membership. The Special journals include:

Archives of Internal Medicine
American Journal of Diseases of Children
Archives of Dermatology
Archives of Neurology and Psychiatry
Archives of Pathology
Archives of Surgery
Archives of Otolaryngology
Archives of Ophthalmology
Archives of Industrial Health

The same publication will be mailed from year to year, unless the doctor of medicine requests a change. No part of AMA dues can be applied as a partial payment on any other publications of the AMA.

DR. BEAUMONT PERSONAL RELIC TO MSMS

Through the generosity of the St. Louis Medical Society, a magnificent rosewood bed once owned by William Beaumont, M.D., has been donated to the Michigan State Medical Society for the permanent exhibit of the Beaumont Memorial on Mackinac Island.

The relic has been in the Beaumont Collection of the St. Louis Medical Society since 1947, the gift of Mrs. George K. Conant. The bed was first acquired by a daughter of Dr. Beaumont, Mrs. Sarah Keim, who years later sold it to a close friend (who was Mrs. Conant's aunt) when she moved into an apartment in 1914. Mrs. Conant received the heirloom as a gift from her aunt.

The bed is reported to be in excellent condition, and will be placed on display at the Beaumont Memorial for the 1955 summer season.

WHEN IS YOUR BIRTHDAY, DOCTOR?

From a small beginning, leaders of the Michigan Foundation for Medical and Health Education, Inc., have hopes that the "birthday contribution" movement, which started in Muskegon, will snowball to the point where it will play a significant part in building the Foundation's Student Loan Revolving Fund.

Early participants were William M. LeFevre, M.D., of Muskegon, Otto Van der Velde, M.D., of Holland, E. L. Carr, M.D., of Lansing, and B. R. Corbus, M.D., Grand Rapids, each of whom sent a check to the Foundation on his birthday.

With each birthday as a reminder, donors will get

(Continued on Page 742)

READING TIME—1 MINUTE

A FEW FACTS FOR THE BUSY DOCTOR WHO WANTS THE

Latest Information About Filter Tip Cigarettes

Your patients are interested in cigarettes! From the large volume of writing on this subject, Brown & Williamson Tobacco Corp. would like to give you a few facts about *Viceroy*.

Only Viceroy gives you, your patients, and all cigarette smokers 20,000 Filter Traps in every filter tip. These filter traps, doctor, are composed of a pure white non-mineral cellulose acetate. They provide the maximum filtering efficiency possible without affecting the flow of smoke or the full flavor of Viceroy's quality tobaccos.

Smokers report Viceroys taste even better than cigarettes without filters.

King-Size Filter Tip

VICEROY

World's Most Popular Filter Tip Cigarette

Only a Penny or Two More Than Cigarettes Without Filters

(Continued from Page 740)

"in the habit" of making yearly contributions, giving the Foundation a steady income and making it easier for contributors to participate by spreading gifts over a long term.

When is your birthday, Doctor? Your contribution—small or large—will be a great help in the effort to assist young medical students who need a boost to complete their education and serve the rural communities of Michigan.

* * *

One of Michigan's finest speakers and best-known citizens, Charles L. Anspach, Ph.D., will present the traditional Biddle Lecture, highlight of Officers Night on Wednesday, September 28, at the MSMS 90th Annual Session in Grand Rapids.

Dr. Anspach is President of Central Michigan College of Education, Mount Pleasant, and a leader in educational affairs and social service. Before becoming head of Central Michigan in 1939 he was Chairman of the Department of Education at Michigan State Normal College, Ypsilanti, and Dean and President of Ashland College, Ashland, Ohio.

Michigan's largest county has now joined the growing list of forward-looking counties which have scrapped the antiquated coroner system in favor of an up-to-date medical examiner's office. So far eight counties have taken advantage of new law passed by the 1953 Legislature under sponsorship of MSMS, three in the April election and five last November.

According to information received by MSMS, during the past year, voters in these counties have acted to replace coroners with M.D. medical examiners: Wayne, Mecosta, Van Buren, Ottawa, Wexford, Allegan, St. Joseph, and Hillsdale.

Oakland, Kent, and Genesee counties already had set up the medical examiner system under special legislation adopted prior to the 1953 act.

In almost every county, the County Medical Society has been a major factor in establishing the medical examiner system.

Plea to Force Health Setup Use Denied.—A circuit judge Tuesday refused to issue a temporary injunction which would have required five medical agencies to permit Dr. William A. Kopprasch, Allegan physician, to use the Allegan County Health Center for his practice.

Judge Raymond L. Smith said he based his decision on Dr. Kopprasch's failure to comply with the hospital's by-laws in not filling out an application blank for permission to use hospital facilities.

The doctor "should not try to get in the back door when the front door has not been legally barred," Smith declared.

* * *

Dr. Kopprasch has filed a $250,000 suit against the Health Center and its board of directors as well as the

Allegan County Medical Society, the Michigan State Medical Society and the Michigan Hospital Association. He contends the defendants are conspiring against him in forbidding him to practice at the Health Center, a community hospital.

The suit also charged that other Allegan physicians are unhappy because he gave testimony contrary to theirs in civil and insurance court cases.

* * *

"G-Day" in Glendale.—On March 9, 1955, a glaucoma-day study was made in Glendale. With a population of 114,400 people, everyone over forty years of age was invited to attend a study conducted by the Lions Club and eight ophthalmologists and their office staffs.

The suggestion came from Mrs. Harry Gradle, widow of the famed Chicago ophthalmologist and glaucoma specialist who was trained at the University of Michigan. Seven hundred and two persons were examined that day, having vision tests, tension, fundus examination, and where indicated, field of vision. Fourteen unsuspected glaucoma cases were discovered, 2 per cent of those examined. This is a striking evidence of the incidence of glaucoma.

* * *

Jerome W. Conn, M.D., Ann Arbor, has been named the new editorial specialty advisor for endocrinology, for *Current Medical Digest*. Dr. Conn has to his credit more than 110 publications in the fields of metabolism and endocrinology. He served as Council President for the Central Society for Clinical Research in 1954, and since 1947 has been consultant to the Surgeon General of the U. S. Army; member of the Fellowship Board National Research Council; member of Committee on Metabolism in Trauma of the Armed Services Epidemiological Board.

* * *

LeMoyne Snyder, M.D., Lansing, presented a paper entitled "Medicolegal Investigations of Suspected Crimes" at the 163rd Annual Meeting of the Connecticut State Medical Society, held in Stratford, Connecticut, April 26, 27 and 28, 1955.

* * *

The State Bar of Michigan, in co-operation with the University of Michigan Medical School and Wayne University College of Medicine together with the State Bar Committee on Medical Jurisprudence and the Michigan Law Institute, presented the Second Medicolegal Institute, April 21 and 22, 1955, at the Sheraton-Cadillac Hotel in Detroit.

* * *

Otto Tod Mallery, Jr., M.D., Director of the Institute of Industrial Health, University of Michigan, has been appointed to the Medical Advisory Council for the American Association of Industrial Nurses.

* * *

Enzyme Symposium.—A three-day International Symposium on Enzymes: Units of Biological Structure and Function, sponsored by the Henry Ford Hospital and The Edsel B. Ford Institute for Medical Research will be held in the auditorium of Henry Ford Hospital, November 1, 2, and 3, 1955.

Interrelationships between enzymology and other fields,

notably genetics, physiology, biochemistry, and pharmacology, will constitute the general theme of the Symposium. The specific topics for the six sessions will be: Origin of Enzymes, Status of the Gene-Enzyme Relationship, Enzymes and Cell Structure, Enzymatic Basis of Some Physiological Functions, Cellular Energy Sources, and Regulation of Enzyme Activity. More than thirty internationally known scientists have accepted invitations to participate.

Interested persons may secure a copy of the Preliminary Announcement by writing to Dr. Clarence E. Rupe, Henry Ford Hospital, Detroit 2, Michigan.

Invitations will be sent to as many as can be accommodated.

* * *

Eight University of Michigan medical students made their first public presentations of scientific papers, Thursday, May 12, 1955.

A new educational device in the training of undergraduate medical students, the public presentation took place in the Main Amphitheater of the University Hospital sponsored by Alpha Omega Alpha, the medical equivalent of Phi Beta Kappa.

Called "The First Annual Student Night," the event included papers on various subjects in clinical and experimental medicine, including the use of Cobalt in sterilizing tissue culture, alcoholism, metabolism, and enzyme studies.

The U-M undergraduate research program is considered unique in that it provides carefully organized clinical research training for students working toward an M.D. degree. Customarily such medical research is reserved for graduate students working toward an advanced degree.

Dean Albert C. Furstenberg of the Medical School who initiated the program, declared, "The modern medical school curriculum is already demanding. Try as we have, there seems no way to include training in scientific method."

He added, "Therefore, we are excited that as an extra-curricular device, made possible through the financial support of pharmaceutical houses and foundations, our students are receiving valuable training in laboratory investigation."

The U-M Medical School makes a limited number of $500 research grants available to top undergraduate students. Each student develops an interest in a special area of medical research, and he is assigned a faculty sponsor.

In the past the student submitted a technical paper to the dean and his committee at the end of the research. This year for the first time the student will get actual practice in presenting his findings publicly.

Each student was permitted ten minutes in which to

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read his paper and present his findings. Dr. Holbrooke S. Seltzer, assistant professor of internal medicine, will preside, and Dr. Burton L. Baker, professor of anatomy, made the closing critique.

Students presenting papers were: W. Ford Keitzer, physiology, 293 Castle Blvd., Akron, Ohio; Charles L. Votaw, anatomy, 1417 E. Hile, Muskegon; Gerald J. Gleich, biochemistry, 912 S. Second Ave., Escanaba; Nancy F. Thomas, anatomy, 987 S. Shore Dr., Holland; John L. London, internal medicine, 408 Cottage, Olivet; Victor Bloom, pharmacology, 1445 University Terrace, Ann Arbor; Richard D. Stewart, bacteriology, 1448 University Terrace, Ann Arbor, and Gerald D. Abrams, anatomy, 18475 Northlawn, Detroit.

Research projects conducted by these students were variously financed by the National Foundation for Infantile Paralysis, the U-M Michigan Memorial-Phoenix Project, the Difco Laboratories, Lederle Pharmaceutical Company, and the U-M Undergraduate Medical Research Fellowships.

* * *

Dr. Louis J. Hirschman was honored at Wayne University's 87th annual alumni reunion Saturday, May 14, 1955, in Detroit's Sheraton-Cadillac Hotel by being presented the University's Alumni Award.

Dr. Hirschman, who was graduated from the Wayne University College of Medicine in 1899, was honored along with Walter F. Carey, president of Automobile Carriers, Inc., Vernon L. DeTar, nationally known organist and choirmaster; Dr. Joseph J. Katz, senior chemist at Chicago's Argonne National Laboratory, and Florence E. Kuhn, assistant superintendent of the Detroit public schools.

The author of several textbooks in his professional field of proctology and chapters in the Yearbook of Anesthesia, Dr. Hirschman is currently associate editor of the *American Journal of Surgery* and of the *American Journal of Digestive Diseases.*

In addition to teaching on the Wayne faculty from 1904 until 1946, he has also served as president of the Michigan State Medical Society, Wayne County Medical Society, American Proctological Society, Wayne University College of Medicine Alumni Association, Detroit Academy of Medicine, and the Detroit Medical Club of which he was a founder. In 1952, he was awarded the Distinguished Service Citation of the Wayne University College of Medicine Alumni Association.

President Clarence B. Hilberry of Wayne, who presented the alumni award, praised Hirschman for his "driving search for greater scientific knowledge and improved surgical procedures, and their quick dissemination through conferences and symposia. Wayne," said President Hilberry, "is proud to be the spokesman of a grateful community to this great surgeon trained among us and returning to us the full gift of his talents."

Dr. Hirschman now makes his home in Traverse City, Michigan.

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The Tenth Rheumatism Review, a comprehensive review of the American and English literature of recent years, is being made available for the first time to the medical profession at cost by the Arthritis and Rheumatism Foundation.

Physicians may obtain their copies of the *Review* by sending $1.00 to the Arthritis and Rheumatism Foundation, 23 West 45th Street, New York 36, New York.

The 418-page *Review* is based on material culled from 2,250 medical and scientific papers published in the field of arthritis and the rheumatic diseases over a five-year period. Written in straight prose and marked for reference, it was prepared by the Editorial Committee of the American Rheumatism Association, the professional society in the field. The book comes complete with index and bibliography.

* * *

The 1955 AMA Clinical Session will be held in Boston, November 29 through December 2, 1955. All doctors of medicine who desire a place on the Program should communicate immediately with the Chairman of the Program Committee, Theodore L. Badger, M.D., c/o Massachusetts Medical Society, 22 The Fenway, Boston 15. Applications for space in the scientific exhibit should be made now to Council on Scientific Assembly, AMA, 535 North Dearborn Street, Chicago 10, Illinois.

* * *

Coleman Mopper, M.D., Detroit, on April 12, at Savannah, Georgia, addressed the Georgia Medical Society on the subject, "Some Dermatological Manifestations of Internal Conditions."

* * *

At the Student American Medical Association's Fifth Convention in Chicago, May 6-7-8, 1955, a record total of 1,182 was registered—an increase of 226 over the previous record made in 1954. The convention was conducted by Executive Director Russell F. Staudacher, formerly associated with the Michigan State Medical Society Executive Office.

MRS. CHARLOTTE ASH

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gan State Medical Assistants Society, Charlotte has still found time to spend with her old friends and with many new. She is not at all disappointed about the fact that unforeseen events changed the hopes and plans she had made as a high school student, for she has found happiness in the career of Medical Assistant which she so capably fills.

Charlotte Ash stands as an excellent example of the successful Medical Assistant and the Society is, indeed, proud of her.

—HALLIE CUMMINS

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

PUBLIC RELATIONS IN MEDICAL PRACTICE. By James E. Bryan, Administrator, Medical-Surgical Plan of New Jersey. Formerly Executive Secretary, Westchester County Medical Society; Executive Secretary, New York County Medical Society; Executive Officer, The Medical Society of New Jersey; Chairman, Medical Society Executives Conference. Foreword by Louis H. Bauer, M.D., F.A.C.P., Secretary-General, The World Medical Association; Chairman of the Board, United Medical Services of New York; President, American Medical Education Foundation; Past President, American Medical Association. Baltimore: The Williams & Wilkins Company, 1955. Price, $5.00.

The physician, as a public servant, must constantly strive to do things which meet with public approval. The man of medicine is more than a healer. He is a member of a community, his County Society, his neighborhood. He cannot seek seclusion or try to avoid social contacts which are implements through which he must sell the public that he is interested in their needs and problems, and thereby motivated to do mankind a service that is sincere and unselfish.

The author of this text is not a physician, but has worked in close alliance with the medical profession for many years. He, therefore, can give a much more unbiased expression to the problem of public relations.

The physician is no longer a "tin god" on a pedestal. He must project himself into various social strata, community functions and government, as he represents himself he represents the entire profession. He must sense public needs, sentiments and then sincerly approach these needs to a solution.

This text should be found in every physician's office and is required reading. We must face what the public thinks of the profession and then correct what is wrong.

The author has covered the entire field of public relations, as it applies to medicine, in an exhaustive manner. The text is extremely well written and is easy to read.

V.B.L.

THE MEDICAL CARE OF THE AGED AND CHRONICALLY ILL. With Particular Emphasis on Degenerative Disorders, Advanced Cancer and Other as yet Incurable Diseases. By Freddy Homburger, M.D., Research Professor of Medicine, Tufts College Medical School. Boston and Toronto: Little, Brown and Company, 1955. Price, $5.75.

With the advancement of better living conditions and medical care, we are adding to the longevity of the human race. With all advancements, problems arise. The problem of geriatrics is, indeed, a foremost problem which is going to become even more important in the next few years. The problems of the aged and the chronically ill are crucial problems that must be met.

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The text is well written and will be of great value to nurses, relatives and physicians alike. The text offers to the physician readily accessible knowledge in the care of the chronically ill.

The indexing is well done. The book in its entirety is exceedingly well done and can be recommended for nurses, practitioners and medical students. V.B.L.

HEMATOLOGY. By Cyrus C. Sturgis, M.D., Professor of Internal Medicine, Chairman of the Department of Internal Medicine, University of Michigan Medical School and Director of the Thomas Henry Simpson Memorial Institute for Medical Research, University of Michigan, Ann Arbor, Michigan. 2nd ed. Springfield, Illinois: Charles C Thomas, 1954. Price, $19.50.

This is the second edition of a text that is becoming the bible of hematology. Many revisions have occurred since the first edition which makes this voluminous text on hematology a "must" for every clinician's library. The author's clear, concise style of writing reflects a tremendous wealth of knowledge, research and experience which is placed in print with a clarity that makes the text very easy reading.

The author's approach to the field of hematology is the clinical-morphologic approach which makes the text even more valuable. Many texts on hematology approach the problem from the morphologic standpoint, which appeals to the microscopists and pathologists but loses the clinician. This text makes it possible for the clinician to assimilate both the clinical and morphologic aspects of hematology.

The photomicrographs found throughout the text are excellent. The tables and graphs are well done and easily interpreted. The author's extensive experience, study and contributions to the field of hematology have been tremendous, and as the author of a difficult text subject such as hematology this text meets the most rigid standards as an outstanding contribution to medical libraries.

On the subject of pernicious anemia and macrocytic anemias, the author is unexcelled. The subject is covered in an exhaustive manner and embraces the recent contribution to the subject. The subjects of aplastic anemia and agranulocytosis are exceedingly well done. The entire text embraces the field of hematology in a clear-cut exhaustive manner.

The most recent advances in the field of hematology are included within the confines of the covers of this text.

The indexing is excellent. The bibliography is exhaustive, recent and replete.

This text cannot be recommended too highly as a "must" for hematologists, clinicians and medical students.

V.B.L.

THE CARE OF YOUR SKIN. By Herbert Lawrence, M.D. Illus. Boston-Toronto: Little, Brown and Company, 1955. Price, $2.50.

This is a small book of ninety-five pages, written for

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the patient with acne to help him understand the treatment of his condition. It is an important book because a majority of individuals in their teen years and twenties have acne.

The author is a qualified dermatologist and his material is based on modern scientific knowledge. He discusses causes, misconceptions, treatment and even the emotional problems of acne.

The patient would receive more value for his money in buying this book rather than buying the highly advertised "sure-cures" which may do more harm than good.

H.E.A.

THE PRINCIPLES AND PRACTICE OF MEDICINE. A Textbook for Students and Doctors. By L. S. P. Davidson, B.A. Contab., M.D., P.R.C.P.Ed., F.R.C.P.-Lond., M.D. Oslo Physician to H.M. the Queen in Scotland, Professor of Medicine and Clinical Medicine, University of Edinburgh, Physician-in-Charge, Royal Infirmary, Edinburgh, and The Staff of the Department of Medicine, University of Edinburgh, and Associated Clinical Units. Second Edition. Edinburgh & London: E. & S. Livingstone, Ltd., 1954. Price, $7.00.

This text does not approach standard American texts on medicine. It is written in a didactic manner, not exhaustive. The electrocardiography is limited to standard leads. Reference to drugs is sometimes in Edinburgh nomenclature.

This text was born from necessity. It is a compilation of a series of lectures given by the authors to medical students over a period of years. The bibliography is minute.

The index is adequate. The text can be recommended as a quick reference and as a text for medical students and nurses.

V.B.L.

CIBA FOUNDATION SYMPOSIUM ON THE KIDNEY. Arranged jointly with the Renal Association. Editor for the Renal Association, A. A. G. Lewis, B.Sc., M.D., M.R.C.P. Editor for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch. Assisted by Joan Etherington. 125 illustrations. Boston: Little, Brown and Company, 1954. Price, $6.75.

The Ciba Foundation was organized in London in 1947 as an educational and scientific charity. It provides an international center where workers, active in medical and chemical research, meet and exchange ideas. The membership is small, so the reports are published. The kidney study is the ninth.

The book of 333 pages has five parts: (1) Structural and Functional Relationships in the Kidney, (2) Tubular Functions Other than the Regulation of Acid-Base Balance, (3) Renal Share in the Regulation of Acid-Base Balance, (4) General Problems of Electrolyte Excretion, (5) Renal Share in Volume Control of Body Fluid.

All the papers and discussions are reproduced. In all there are twenty-one papers reported with nineteen discussion reports.

DOCTORS IN THE SKY. The Story of the Aero Medical Association. By Robert J. Benford, M.D., Colonel, Medical Corps, United States Air Force. Springfield, Illinois: Charles C Thomas, 1955. Price, $8.75.

This text is a historical compilation of aviation medicine from 1929 to 1954. The text records the vast amount of knowledge and research that has gone into the development of aviation and the memorable contributions to the field.

The text also records the annual Aero Medical Association meetings. Of special interest to the Michigan group will be the important role played by Dr. F. C. Warnshuis of Grand Rapids in the development of aviation medicine.

The text is very pleasant reading and informative. The text can be highly recommended to all who have any interest in aviation, physicians and laymen alike.

V.B.L.

PUBLIC HEALTH SERVICE EXPANDS FOR CIVIL DEFENSE

The Public Health Service has been assigned extensive new defense responsibilities as the result of a delegation by the Federal Civil Defense Administration to the Department of Health, Education and Welfare recently approved by the President. A major expansion and reorganization of the Commissioned Reserve of the PHS as a national defense measure has been announced by Surgeon General Leonard A. Scheele. The Service expects to commission an additional 2,000 reserve officers by June 30, 1955, and present plans call for the commissioning of another 3,000 officers during the 1955-56 fiscal year.

Communication

Dear Doctor Haughey:

An article in the February, 1955, issue of THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY entitled "Michigan Maternal Mortality Study 1950-1952" referred to one of our products, Pentothal, as though the name were the common designation for the product. Actually, Pentothal is the Abbott trade-mark for thiopental.

We realize that there are thousands of trade-marks in use today and that it is impossible for anyone to recognize all of them. On the other hand, use of the name as a common word may ultimately result in loss of exclusive ownership of the trade-mark, and that is why we are writing you.

We are enclosing an up-to-date list of the Abbott trade-marks for your reference, and would greatly appreciate it if your proofreader could, whenever any of these names is used in future issues of THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY, capitalize the word, quote it, or otherwise distinguish it from the rest of the type. We thank you for any assistance you can give us in helping us preserve our trade-marks.

Very truly yours,
JOHN H. SCHNEIDER
Patent Counsel
Abbott Laboratories

Chicago, Illinois
March 30, 1955